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QUALITY OF CARE UNDER MEDICARE'S PROSPECTIVE PAYMENT SYSTEM

Volume I

HEARINGS

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

NINETY-NINTH CONGRESS

FIRST SESSION

WASHINGTON, DC

MEDICARE DRG'S: CHALLENGES FOR QUALITY CARE
SEPTEMBER 26, 1985

MEDICARE DRG'S: CHALLENGES FOR POST-HOSPITAL CARE
OCTOBER 24, 1985

MEDICARE DRG'S: THE GOVERNMENT'S ROLE IN ENSURING QUALITY
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MEDICARE DRG'S: CHALLENGES FOR QUALITY CARE

THURSDAY, SEPTEMBER 26, 1985

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The special committee convened, pursuant to notice, at 9:00 o'clock a.m., in room SD-628, Dirksen Senate Office Building, Hon. John Heinz, chairman, presiding.

Present: Senators Heinz, Glenn, Grassley, Warner, Burdick, Wilson, and Cohen.

Staff Present: Stephen R. McConnell, staff director; Robin L. Kropf, chief clerk; James Michie, chief investigator; David Schulke, investigator; Isabelle Claxton, communications director; Sara White, deputy communications director, Diane Lifsey, minority staff director; Jane Jeter, professional staff (minority); Kimberly Kasberg, staff assistant; Diane Linskey, staff assistant; and Dan Tuite, printing assistant.

OPENING STATEMENT BY SENATOR JOHN HEINZ, CHAIRMAN

Chairman HEINZ. Ladies and gentlemen, good morning. We will come to order.

Two years ago next week, Congress responded to skyrocketing health care costs and the imminent bankruptcy of Medicare with changes in the reimbursement method for hospitals under part A of the program. Using diagnosis related groups, or DRG's, as they are called, hospitals are reimbursed for care on a predetermined, specific rate for a specific diagnosis.

From the beginning, this committee has been concerned that DRG's make older Americans on Medicare potential victims of poor quality care. Specifically, I have expressed concern on several previous occasions that hospitals might attempt to hedge the system through premature discharges or inappropriate transfers of patients. I have also warned that the watchdog Peer Review Organizations, the PRO's, might be tied to the fence on a short leash when it comes to quality oversight and enforcement.

Repeatedly over the past months, this committee has asked the administration's help in resolving conflicting reports on DRG abuses and unnerving evidence that no corrective actions have been taken. But they have not, I am sorry to say, shared our sense of urgency, it seems, nor our view of how deeply flawed the DRG system may be.

The committee has just completed its own 4-month investigation of the impact of DRG's on the quality of care received by Medicare beneficiaries. The major findings of this investigation include the following:

First, seriously ill Medicare patients are being denied admissions to hospitals or are being catapulted out of hospital doors prematurely as a result of inflexible, inaccurate pricing and packaging of illnesses. And patients are judged as "DRG winners or losers," depending on the profit potential that they represent under this current payment system.

At least in part, the packaging problem is that the DRG's fail to account for differences in severity of illness, and the likelihood that an older patient may suffer from not a single, but multiple conditions, which cannot be categorized under a single diagnosis.

Second, for physicians around the country, DRG's have created a dilemma of medical ethics versus profitable practice. Basically, financial incentives provided by the DRG's result in hospitals pressuring doctors to violate their own medical judgment in treating patients. It is not uncommon for a hospital to publicly rank the performance of its doctors with the highest kudos going to those with shorter stay, money saving patients and black marks for doctors whose patients' stays are longer and cost more.

Third and finally, the quality abuses we have documented under the DRG system cannot be properly monitored and sanctioned by the Peer Review Organizations under current administration guidelines. PRO's cite vague, confusing, and conflicting information from the Health Care Financing Administration regarding their monitoring responsibilities. They feel hamstrung without meaningful, effective enforcement powers, and they feel financially vulnerable given current contract arrangements with the Health Care Financing Administration.

Without strong, sharply focused instructions and appropriate sanction authorities, the Peer Review Organizations can offer little assurance for the Congress and for the American people that quality has not gone out of care under Medicare.

At this time, I would like to enter the full report of the committee's staff investigation in to the record.[1] Highlighted at the end of the report are several specific recommendations for actions to correct some of the most blatant loopholes and oversights in the DRG's.

Chairman HEINZ. We have a full schedule today, and I look forward to the comments of our witnesses, but first I want to recognize the ranking minority member of the committee, Senator Glenn.

STATEMENT BY SENATOR JOHN GLENN

Senator GLENN. Thank you, Mr. Chairman. I welcome our witnesses here today.

As ranking Democratic member of the Senate Special Committee on Aging, I am pleased that the committee has begun its examination of quality of care questions surrounding the phasing-in of prospective fixed payments by DRG's, diagnosis related groups, for the hospital care of Medicare beneficiaries. Today's hearing, "Medicare DRG's: Challenges for Quality Care," is the first of several hearings which the committee intends to hold to explore quality of care issues facing the Medicare program.

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[1] See p. 314.

With enactment of the PPS, prospective payment system, in 1983, we dramatically changed the nature of Medicare reimbursement to hospitals. This conversion from cost-based retrospective reimbursement to fixed payments reflected the administration's and Congress' determination to reduce rapidly increasing Medicare expenditures. Had program growth continued unrestricted, with average yearly increases averaging 19 percent, the Medicare hospital insurance trust fund would have become insolvent by the end of this decade.

I am pleased we are achieving our cost containment goals for Medicare and improving the financial health of the trust fund. However, ever since PPS was enacted 2 years ago, Congress' objectives have stretched beyond simple dollars and cents savings. The intentions were and are today to rein in inflation and unnecessary spending without sacrificing the quality of medical care available to Medicare beneficiaries. It is the unnecessary spending that we have been after, not the revenue essential to provide high quality health services to elderly beneficiaries in need.

Congress created Peer Review Organizations, PRO's, to be the watchdogs of the Prospective Payment System, PPS. By its very makeup of fixed payments being made on a per admission/per diagnosis/per discharge basis, the new DRG system mandated strict, accurate and high quality utilization review. The PRO's were designed to redflag health care providers who might attempt to endrun the system through increased admissions or reductions in care. Specifically, Congress included the following as potential abuses: Unnecessary or multiple admissions, premature discharges, and inappropriate patient transfers. The PRO's were given the job of reporting any such abuses to the Health Care Financing Administration. In turn, the Department of Health and Human Services was authorized to deny payments to practitioners found to be providing unfit or unnecessary care, or to take other corrective actions including prohibiting them from future participation in Medicare.

In the Congress, we have always known that the impact of PPS needs to be closely monitored. Under this new reimbursement system, the rules of the game and financial incentives have changed immensely. And, as widespread consequences of changes are being implemented in the largest health care financing program in the United States, we need to be guarding against the new forms of program abuse and/or misunderstandings that might crop up, in addition to shortcomings of the program structure itself.

We are now approaching the end of the second year of the three-year phase-in of the Medicare DRG prospective payment system, which began with each hospital's first cost reporting period on or after October 1 of 1983. During the past year or so, some of us have heard anecdotal stories of the system not working—of beneficiaries being told that their Medicare hospital days had "run out" because of the new DRG's. These types of allegations may be the ones people most often like to repeat because there is an obvious "bad guy."

The truth is we are just beginning to get the feedback we need to make an honest evaluation of how the Medicare DRG's are working. And, in examining DRG's for any shortcomings, we need to look to fine-tune the system from all angles. Some competent and caring health care providers in Ohio—who want to provide the best level of care possible to Medicare beneficiaries—have shared some of their own concerns with me. In certain instances, their comments have focused on how the pricing mechanisms can be adjusted for advancements in medical technology. At other times, their observations have concentrated on problems and uncertainties with the performance of the Peer Review Organization.

And quite frankly, I am not sure that we are going to find any clear cut set of problems with the DRG's, which means "solutions" are going to be more difficult to formulate and agree upon. However, as every member of this committee knows, the Medicare program's success is only as good as the quality of the health care that it delivers. If we find problems, we are going to correct them.

The elderly and disabled Americans served by Medicare represent an unusually vulnerable group of citizens. A large majority live on fixed incomes and a disproportionate number suffer from chronic diseases. These Americans are not typical in their health care needs, resources or concerns. Moreover, those most likely to be hospitalized tend to be the oldest beneficiaries with the least income, and the most likely to be alone, no one else to help them out or help care for them. Often, they are older women without family members living nearby to help them through their illness. So I look forward to exploring how we can better meet the health care needs of these beneficiaries. Thank you, Mr. Chairman.

Chairman HEINZ. Senator Glenn, thank you very much for a most thoughtful statement.

The Chair now recognizes a member of this committee who, in a sense, has double duty on behalf of the elderly. Senator Grassley serves on the Labor and Human Resources Committee, and on that committee, he chairs the subcommittee that deals with the Older Americans Act and many other authorities important to senior citizens. And, of course, we have been privileged to have him as a valued member of this committee for a number of years. The senior—you are getting to be the senior Senator from Iowa.

Senator GRASSLEY. I am 52 years old.

Chairman HEINZ. 52 years old. Senator Grassley.

STATEMENT BY SENATOR CHARLES E. GRASSLEY

Senator GRASSLEY. Thank you, Mr. Chairman, and I am going to insert my statement, but I would like to point out two things: One, as chairman of the Senate Subcommittee on Aging, Senate Labor and Human Resources Committee, I held a hearing in Iowa the second week in August on much the same subject. Of course, most of the witnesses were from my State. So, from that standpoint, geographically, it has a narrow focus, but from the standpoint of the problems that you will hear today, I assume that I did not hear too much different at that hearing than we will today. But I would suggest that you and I compare notes from your record here and from the record that we have of that hearing, so that we can particularly focus upon special problems that might relate to rural hospitals. We have a tremendous problem in my State of DRG's impact because of the rural/urban wage index, how it impacts upon rural hospitals. And I have to be more sensitive to the concerns of people from metropolitan areas where there might be special problems as well. So there can be that cross-fertilization of your hearing versus mine and see if we can have a common understanding.

Second, for all the witnesses, because I will not be able to be here except for the first panel, I would like to suggest that I am looking for people who say that the DRG's were absolutely the wrong approach and it ought to be dumped. Now, so far I have not heard that too much. It is mostly a case that, yes, we had to do something in the area of cost control and the DRG's are a place to start, but. And then from that conjunction "but," there is a lot of movements in a lot of different directions of ideas of how they ought to be changed.

But, for instance, I want to hear if there is anybody who believes that it was a mistake and we ought to go back to square one and not start over, or we ought to go to square one and start over with something else.

Second, I will be looking for a consensus of where things ought to be after that word "but." The extent to which there is a consensus that certain things ought to be done in a certain way with the DRG's.

Now, Senator Glenn has already said that after 3 years, we committed ourselves to a review. So in this hearing, plus lots of other hearings in other committees that have some jurisdiction over DRG's, we are looking for that point by 12 months from now where we have a consensus of what needs to be done after that original 3-year commitment.

Beyond that, Mr. Chairman, I will submit a written statement for the record.

[The prepared statement of Senator Grassley follows:]

STATEMENT OF SENATOR CHARLES E. GRASSLEY

I appreciate the opportunity to be here this morning to hear the testimony of our witnesses on the Medicare prospective payment system and its implications for quality of care. Just last month, I held a similar hearing in my state of Iowa through my chairmanship of the Subcommittee on Aging in the Senate Labor and Human Resources Committee. We examined the Medicare prospective payment system at its two-year mark and examined its impact on health care providers and Medicare beneficiaries.

We all recognize the need for Congress to change the way the Medicare program reimbursed hospitals to a prospective payment system. The Medicare system could not have sustained prolonged growth of 22 percent like it experienced in 1981. Such rapid increases in hospital expenditures would have jeopardized the provision of health care for all our elderly citizens.

The traditional retrospective cost-based method of hospital reimbursement provided no incentives for hospitals to be cost-conscious. In the past, Medicare rewarded increased expenditures—not prudent management. The prospective payment system we created in 1983 in Public Law 98-121 has dramatically slowed the growth of Medicare Part A. But along with the impact of PPS on cost of care, it also has implications for the quality of care for beneficiaries.

One of the cost-containment aspects of the prospective payment system is the built-in incentives for hospitals to both admit patients and to discharge them earlier. The Peer Review Organizations were created and charged with the important role of monitoring the validity of diagnostic information, readmission rates, appropriateness of services and other measures of quality. I think it is safe to say that the Health Care Financing Administration has put a greater emphasis on its utilization reviews, rather than ensuring that financial incentives in the DRG system don't violate good medical judgment and encourage substandard care of beneficiaries.

Previous Congressional hearings have added weight to growing concerns about premature discharges, lack of post-acute care options, and misunderstandings among beneficiaries and providers on DRG procedures and discharge appeal rights. Even in my hearing in Iowa, anecdotal information was relayed to me that patients are being released much earlier from hospitals and are being sent to nursing homes which are ill-equipped to address their heavy care needs. Even more at risk are those elders with heavy care needs who are released to their homes in communities that lack programs of comprehensive community based care.

However, one of my concerns is that much of the information we have available on quality of care is strictly anecdotal. I hope that HCFA can reevaluate its approach to quality of care review so we have a better basis on which to assess the DRG system.

Mr. Chairman, I look forward to hearing the testimony of our distinguished witnesses this morning to help us shed some light on these issues.

Chairman HEINZ. Senator Grassley, I think those are very well-taken comments. You are quite right. DRG's have been very important as a cost saving measure; Medicare, which was threatened with bankruptcy within the next 2 or 3 years, now appears to be in substantially healthier financial condition. And a financial crisis in Medicare is not expected until the next decade. Well, that is progress.

DRG's can be an effective cost control mechanism, but if we are not very careful in the way this system is implemented, I worry that we will find that if there are flaws, that the flaws will become so big and bad that the system will in its entirety be scrapped, and I am not quite sure what the alternative might be. But I think whether one is for the system or has an instinctive dislike for it—I do not have an instinctive dislike for it—it is time for Congress to very carefully look at what is going on out there. It is time for the administration to look at what they have created; it is time for the administration to actually appoint some people into the jobs that are supposed to monitor what is going on. We have far too many unfilled management positions in the Department of Health and Human Services. Everybody is in acting capacity, which means that they are not acting, except in name.

So we have some problems, and I think your points were all extremely well taken, but we must begin to look at this system, and this is the only committee of Congress that so far has focused on the quality of care under DRG's. On the House side, the Ways and Means Committee has not, and neither has the Commerce and Energy Committee. The Senate Finance Committee, on which both of us sit, and which has jurisdiction over Medicare, and the Health Subcommittee of that committee of which I am also a member, they have not looked at this system; and certainly, HCFA has not. There is a need to look at this quality issue squarely in the eye, and, of course, our first panel of witnesses has had some experiences in that regard. So I would like to extend, especially to them, a warm welcome. They have traveled, in many instances, quite far to be with us, one from California and another from Minnesota. I do want to welcome Mrs. Carol Mahla from Minnesota, Mrs. Margaret Buttrill from Virginia, and Mrs. Betty Kratt of California. She is accompanied by Dr. Karl Kellawan, the physician who cared for her mother.

I might add, Mrs Kratt is recently retired from the family's own auto parts and repair business. I want to thank all three of you women for coming here to share with us what I know were very unfortunate and distressing experiences of close family members, in this case, in each instance, it happens to be a mother, I believe. And at the same time, I want you to know that your testimony is going to help us, I think, to concretely understand how and why a system which we did enact and is meant to care for our senior citizens can, nonetheless, be flawed and become insensitive and sometimes go terribly wrong.

Now, Mrs. Mahla, if we may, could we begin with your story this morning, and could you briefly tell us about your mother's hospitalization earlier this year and what happened afterwards.

STATEMENT OF CAROL MAHLA, DULUTH, MN

Mrs. MAHLA. Yes; this is a brief synopsis of the last weeks prior to my mother's death. She was 75 years old. I believe she was inappropriately discharged from the hospital to a nursing home that could not possibly give her the care and surveillance that she needed. I firmly believe that she did not stand a chance to survive.

Mother was recovering from major abdominal surgery complicated by a very, very severe staph infection. Her surgical incision was reopened to 4 inches and 3 inches deep. I could stick half my hand into that incision, and it was being irrigated twice a day. She then suffered a major heart attack, and she was in critical condition. Six days later after the heart attack, just 2 days out of intensive care, she was approached by the doctor and asked if she wanted to go home in 2 days. And she said, "No way." And I questioned as to why the doctor would even ask her about going home. She had not even been out of bed yet. And on that very same day, that afternoon, while walking with the therapist for the first time, she suffered a cardiac arrest. When I arrived at the hospital into the intensive care unit, I found her alert, awake, but very frightened. She was breathing on her own after 2 hours and attempting to talk.

One-and-a-half days later, I was called at work by my mother's doctor. He informed me that she had suffered a stroke, her left side was paralyzed, she had slurred speech. Then on the phone he asked me if I wanted to put a "Do not resuscitate" on her chart. He indicated that he would also talk to my mother about it. He also told me I was to meet with a social worker that very afternoon about nursing home placement.

I met with the social worker, and I was at a loss for words, I was totally unprepared. I gave her the names of three nursing homes. None had a skilled bed available. Five days passed and I was told that my mother would have to leave the hospital in 2 days. There was a skilled bed available at a nursing home that she would have to take or her Medicare would be pulled.

The available bed was at a nursing home that had been recognized and cited in the newspaper for having the worst care in the city and very substandard. The social worker knew how distraught and helpless I was. I asked if my mother could stay the weekend; the answer was no. I asked what would happen if I refused the bed, and they said that her Medicare would be pulled.

I pleaded with the doctor, and he said—and he looked right at me and said, "Carol, she has to go. The hospital is on my back." At no time by anyone was I verbally or in writing told of my mother's rights under the DRG's, by anyone. In fact, it was 2 months to the day after my mother's death that on my own I went and got this copy of DRG's, and had I ever received this when I needed this information, my mother would have never been discharged from that hospital.

My mother's condition was charted as stable; I could not understand how anyone suffering a major heart attack, a cardiac arrest, a stroke, an open incision and a staph infection could be charted as stable. I told the doctor that, and he said, "Carol, she's fragile." Mother's entire stay in a nursing home exceeded my greatest fears. I will not even go into the humiliation that she suffered.

When my mother was transferred to the nursing home, they did not even send her heart medication with her; she went 12 hours without medication for heart stabilization.

Some of these were so critical. When she was being transferred, she was vomiting, and she continued to vomit until the day she died. I asked how often her vital signs were to be taken: "Once a month." That is quality care, right? And then I went and said, "I want them taken every shift change," which they were.

I ordered a foam mattress. It was not put on the bed for 5 days, and the day it arrived, they stood it in the corner. And the next day when I got there, I asked why was it not put on, she had bedsores, and they said, well, that is the way the day shift is.

I was there most meals feeding her because she was a stroke victim and she had a hard time swallowing. They did not even put a chart on her, input/output. She was building up with fluid for 3 days. I asked and requested a doctor be called, because congestive heart failure is a complication to her type of heart attack. When I finally got so angry I could hear her breathing from the doorway, I went to the nurse and I said, "Did not anybody call a doctor?" She went and got the chart; it was not even charted about her breathing or that I requested it.

They called the doctor; she was put on Lasix for congestive heart failure. Six days later I had my mother transferred to the nursing home of my choice. The care shown her there for 12 hours was fantastic. It was beautiful and they were showing her exactly what should have been shown her the care from the first nursing home. The day that she was transferred, her blood sugar had dropped so low to 40, when I got her to the second nursing home, I pointed it out to the nurse, and the nurse could not believe they had actually transferred her without bringing up her blood sugar. She called the doctor immediately, and they took steps to bring it up.

My mother died on July 19, 6½ days after she was released from the hospital, 12 hours after she was at the new nursing home. I cannot understand how critically ill patients like my mother can be put in a nursing home that are totally understaffed and ill equipped to handle the type of patient that my mother was.

I have had the chief administrators from both nursing homes tell me that they cannot handle the patients they are getting since the DRG's were in force, and I believe them. Had I known again about my rights under the DRG's, the end of my mother's life may not have been different, but the conditions and the trauma in which she died would have been changed because I would have never left her out of that hospital, never, to die like she did.

Chairman HEINZ. Mrs. Mahla, thank you for sharing with us what was obviously a terrible experience for you. Unfortunately, I fear that your experience is not unique.

Mrs. MAHLA. No, it is not.

Chairman HEINZ. Maybe Mrs. Buttrill would—Senator Grassley asked a point of clarification. How large is the city in which the hospital was located, Mr. Mahla?

Mrs. MAHLA. 90,000.

Chairman HEINZ. 90,000 population.

Mrs. Buttrill, I understand that your mother, Mrs. Elsie McIntyre, suffered a massive heart attack, a stroke this past January, and was hospitalized. Could you tell us about your mother's experience in the hospital and what happened afterwards?

STATEMENT OF MARGARET BUTTRILL, NORFOLK, VA

Mrs. BUTTRILL. Well, first, I will tell you it is one of Virginia's largest cities and a very big hospital.

My mother had a stroke and a massive heart attack on January the 12, and under DRG you have to find one illness. So she was entered as a heart attack patient, and sent to intensive care. She was stabilized quickly, brought down into the cardiac floor on a Monday. Mother could not feed herself, she could not talk, she was a brittle diabetic, and had to have food. I went to the hospital and found a regular diet, not diabetic, not pureed, but a regular diet for a patient that could not feed themself. The tray was sitting there, and it was stone cold. The answer I got: "We do not have the time to care for her."

After 12 days, the social worker called me at home, and my daughter, who is here with me, was at my house when she called. She gave me three choices: Take her home, put her in a nursing home, or pay the bill yourself. My mother had care under the Virginia Methodist Conference Plan with Provident Insurance Co. to pay 100 percent. They had paid 100 percent in September. They would not look at the fact that she had other insurance. It was only that I could pay or the family could pay. We had a conference, including all members of my family, my brother-in-law and my sister, who are also here, and the doctor and two representatives of the hospital. They told us she could not stay.

The only way we could get her into a nursing home was to declare she was ready for therapy. A woman that cannot raise her arm, that cannot talk, that cannot feed herself, cannot have therapy. But one nursing home agreed to take her for the 16 days that are allowed under DRG for therapy.

When she was transferred to this nursing home and I got there, they asked me why she was transferred. She could not do anything. She was hypoglycemic! That meant she was down to 40 as far as her blood sugar was concerned. The entire 5 days that she was there, I stood and watched her go almost into a coma; that was a result of the fact that this nursing home could not care for a patient. On the weekend, I asked them if they would kindly call her doctor, and my response was, "Medicare says a doctor only visits every 6 weeks."

Well, I have a temper, and I picked up that phone and called the doctor myself and told him what they said. He said the nurse should have called. We were paying this doctor, not Medicare. The next morning her blood sugar was so low that I put her back in the very same hospital that had forced me to take her out. I also pulled a few strings through friends, and the hospital had received a call that they were not going according to the regulations. There were three nurses when I put her back in the hospital for 30 patients and one orderly.

Now, this woman had been active, she did not look her age, she had a keen mind, and the doctor said, "We are trying everything," but those nurses only looked at 88 years of age. And they said to me, "What are you trying to do? She has lived a good life." And I told them I was trying to save my mother the humiliation that they were giving her. They would change her bed, my mother was a proud lady, and expose her to everybody on the hall. She did have a Clinitron bed which kept down the bedsores, but we had to put nurses on full-time through her private carrier, Provident, for 24-hour service, and we had them for 2 months. It did not cost Medicare one dime. The nurses would administer medication (insuline) to my mother that caused her to go hypoglycemic, because she was on an insulin intake when they felt she needed it. They said, "We did not have time to read the chart." My sister begged them not to give her a shot, and right in front of her the nurse gave it to her. My mother's blood sugar was down to 40, and 6 people in there beating on this little frail woman trying to keep her alive. It was traumatic!

What just made me hot was when they gave me—Medicare paid for these—four plastic pans, because she had been transferred four times, four plastic pans, four plastic bedpans, dirty bed pads that my dogs use.

I definitely feel that my mother would have died anyway, but the quality of care that she got was not what I expected. And I do not understand why they would not accept my mother's second insurance.

Thank you.

Chairman HEINZ. Mrs. Buttrill, thank you for relating a very trying, difficult, and I think Senator Grassley and others would join me in saying, a very shocking experience.

Let me ask Mrs. Kratt what your mother's experience was, and also what happened in terms of her hospitalization and discharge.

STATEMENT OF BETTY F. KRATT, BAKERSFIELD, CA

Mrs. KRATT. Thank you.

I want to thank you for inviting me here today so that I can tell you about the treatment that my mother had while she was in the hospital under Medicare.

My mother was 85 years old when she died early this year. She had been ill with kidney failure, high blood pressure, heart condition, blind, and a loss of hearing.

I entered her in the hospital January 9, 1985, with a heart attack and kidney failure. The hospital took good care of her except for her meals. She was so weak and unable to feed herself. She was on oxygen 24 hours a day and her heart was so bad that her skin color had turned blue. During her hospital stay, my mother required around-the-clock oxygen, she had a catheter, I.V. tubes, and a feeding tube.

Then, on January 29, 1985, I received a call from the hospital stating that my mother would have to go to a nursing home because she no longer needed their acute level of care. On January 31, they sent for an ambulance and transferred her to the nursing home. This was done against Dr. Kellawan's orders and while he was out of town. I was not told anything at all at the time that I could appeal to the hospital to not send her out. I did everything I could to prevent them from moving her, but they told me that Medicare would not let her stay any longer and they were losing money on her.

To make matters worse, the hospital informed the nursing home that she was able to feed and bathe herself and also had bathroom privileges. This was absolutely not true. She could not move at all.

My mother passed away on February 1, 1984, just 14 hours after entering the nursing home. A day or so after her death, I received a letter at my home from the hospital saying that if I did not agree with my mother's discharge, I could send in a written appeal.

I would like to express my feelings about this treatment of my mother and how I was unable to do anything to prevent it. It has been quite a trauma for me. I still wake up at night trying to sort out all the events and what can be done to stop this from happening to our older people. I am 65 years old myself, and my husband is 66, and we are heading down this same road and I do not want any part of it.

I have been very angry over all this. I feel like all of this is what has killed my mother. It is just like murder to me.

Thank you.

Chairman HEINZ. Mrs Kratt, I am going to enter into the record at this point the letter sent to your mother on January 29.

Mrs. KRATT. Yes.

Chairman HEINZ. Which says, and I quote in part: "Our review indicates you now need the type of care normally provided in a skilled nursing facility. You will be eligible for Medicare. Your physician was consulted concerning this matter."

And it also states in part that, "A physician reviewer from our Utilization Review Committee has determined that you no longer require an acute level of care."

Mrs. KRATT. I think that was just a form letter, though.

[The letter referred to follows:]

Hospital

January 29, 1985

Re: Mabel Finch
Health Ins.#550077491 D
Admission date: 1-9-85

Mrs. Mabel Finch
3118 University Avenue
Bakersfield, CA 93306

Dear Mrs. Finch:

During your stay in our hospital, the care you receive is reviewed regularly by our Utilization Review Committee. Utilization review is performed to assure that the hospitalizations are medically necessary and that the services are appropriate. This review follows Federal guidelines.

A physician reviewer from our Utilization Review Committee has determined that you no longer require acute level of care. Our review indicates you now need the type of care normally provided in a skilled nursing facility. Therefore, you will be eligible for Medicare benefits for three additional days, if needed. Thereafter, if authorized, your hospitalization will be covered by Medi-Cal. Your physician was consulted concerning this matter.

If you do not agree with this decision, you may request a reconsideration by filing a written request with the hospital Utilization Review Committee. If you disagree with the Utilization Review Committee decision you may appeal in writing within 60 days to California Medical Review, Inc. (CMRI), 2920 F Street, Suite G, Bakersfield, California, 93301.

If you or your family have any questions regarding this matter, we will be pleased to assist you.

Sincerely yours,

Mary Jo Brown, R.N.
Utilization Review Coordinator

cc: Karl Kellawan, M.D.
Utilization Review Committee
Business Office
CMRI

Chairman HEINZ. Now, I am going to call on your mother's doctor in a minute, but I would just observe that if a fraction of what you have testified to is accurate, the person that wrote this letter, if they knew the facts, has violated Federal law and is subject to sanction. Indeed, as I recollect, the sanction for knowing falsification of such documents is a violation of title 1001 of title 18 of the U.S. Code, and there is a penalty of $10,000 fine and up to 5 years in prison. There are strong civil sanctions as well.

I just wanted to include that in the record, because it illustrates the seriousness of what is involved here.

I want to call on Dr. Kellawan who, I believe, was your mother's physician.

Mrs. KRATT. That is correct.

Chairman HEINZ. Dr. Kellawan, do you agree with everything that Mrs. Kratt has testified to?

Dr. KELLAWAN. She expressed it very well, Senator.

Chairman HEINZ. Would you add anything to what she has said?

STATEMENT OF DR. KARL K. KELLAWAN, BAKERSFIELD, CA

Dr. KELLAWAN. I took care of this fine woman for several years, and she sustained a heart attack at home. We hospitalized her, and I had very good rapport with the family. We discussed her clinical status in great detail, and I told them that my function as a physician here, my job would be to try and keep as comfortable as possible. I consulted a cardiologist, and we both agreed that her heart function could not be improved considerably. We gave her maximum therapy; as she stated, she was on oxygen. We gave her morphine for pain, and to prevent dehydration we gave her some intravenous fluids. She was on a very careful intake and output.

Chairman HEINZ. Is it your opinion that she was discharged from the hospital in an unstable——

Dr. KELLAWAN. Absolutely.

Chairman HEINZ. Well, let me just ask the question.

Was she discharged from the hospital in an unstable condition?

Dr. KELLAWAN. Yes, sir.

Chairman HEINZ. Should a patient ever be discharged from a hospital in an unstable condition?

Dr. KELLAWAN. I thought it was rather inhumane and I told that to the discharge coordinator, I told that to the chairman of the Utilization Committee, and I am still having feedback on this case, because this really disturbed me. They said we will see that this is never done again. But to state that this patient was stable and the condition to be transferred to a nursing home was a lie.

Chairman HEINZ. Let me ask: You have not only had experience with Mrs. Finch, Mrs. Kratt's mother, but you have listened to the testimony of Mrs. Bottrill and Mrs. Mahla regarding their mothers. What does what we have heard indicate to you about the DRG system, to you as a practicing physician?

Dr. KELLAWAN. As a practicing physician, the DRG system to me is a nightmare. The uniqueness about the human being is that we are genetically all different, and my pneumonia will not be the same as your pneumonia. I react to my illness different than you will. And to categorize because I have pneumonia, assigning a certain number of days, and saying in a certain number of days Karl K. Kellawan is supposed to get better, and Senator Heinz will take 3 days to get better, is entirely wrong. It is against all scientific reasoning.

Chairman **Heinz**. Let me ask you this: We have heard stories, again here today, not just here but on other occasions as well, about physicians who are professionals and who are supposed to uphold a certain standard, certain minimum standard of medical care, quality care, that they are being pressured by hospitals and administrators to get patients out of the hospital before they should move out of the hospital. Is there any truth to that?

Dr. **Kellawan**. That is very true.

I have a profile in one of the hospitals I practice. Right now I am a good guy because I make money for them. But next week I may be a bad guy because they lose money.

They can coerce you in many ways. You want to admit patients to the hospital; they say, well, no, there are no beds available. They can intimidate you by endeavoring to get you kicked off the staff when you do not do your charts on time. I am not a surgeon, but, for example, I do certain endoscopic procedures, they can make it difficult for you scheduling your patients. We do not have time to do it; we can do it next week for you.

So there are a lot of techniques that are being developed to so-call punish you.

Chairman **Heinz**. If hospital administrators are pushing doctors around and doctors are letting themselves be pushed, and they are, as a result, discharging patients who should not be discharged, patients who are unstable; and, as a result, patients die or have other slightly less serious things happen to them, do you believe that those doctors risk malpractice suits?

Dr. **Kellawan**. Absolutely. This is a malpractice case. This hospital could have been sued and I could have been involved in the suit.

I mean, she knows this. I know it. As a matter of fact, I discussed this case with a former president of the Medical Society. He said, "Why do you not get a lawyer to sue the hospital?" He said, "That might make them change their tactics." And I am pretty sure they would collect.

Chairman **Heinz**. Have you any idea what the award against the hospital for this kind of malpractice might be?

Dr. **Kellawan**. Well, you know, I am from California. Things are a little different there.

Chairman **Heinz**. What happens there? [Laughter.]

We know that everything is different in California.

Dr. **Kellawan**. Awards are higher there.

Chairman **Heinz**. Give us an idea of the kind of an award.

Dr. **Kellewan**. Oh, I would say a quarter of a million dollars.

Chairman **Heinz**. A quarter of a million dollars?

Dr. **Kellawan**. Yes.

[The prepared statement of Dr. Kellawan follows:]

Statement of Karl K. Kellawan, M.D.

Shortly after you had your press conference in Washington as Chairman of the Special Committee on Aging, I phoned your office and discussed some of my feelings concerning Medicare recipients. Your staff members, Mr. David Schulke and Jim Michie, were extremely courteous.

The DRG system has had a significant impact on Medicare recipients. The DRG system fails to adequately make provisions for differences in age. A 65 year old Medicare recipient who has pneumonia is a lot dfiierent from an 85 year old recipient with pneumonia.

I have been pressured into discharging patients from the hospital because the time allotted under the DRG system had run out. I have also, at times, refrained from ordering certain tests because of the reimbursement considerations. On the other hand, I am fully aware that my failure to order a certain expensive test and missing existing pathology, could result in malpractice litigation.

The DRG system categorizes patients. Patients under the DRG system will receive a level of care that is not equal to the level of care given to private patients or patients with private insurance. Physicians will always be vocal when their patients' care is compromised. DRGs pay for one illness, but most Medicare patients, especially those over 65 have multiple system problems. They are admitted with one disease but other systems problems. They are admitted with one disease but other systems become involved; this requires prolonged hospitalization, increases costs, and time spent with these patients is usually more than with patients under 65 years of age. Trying to make a diagnosis of their multifaceted illnesses is not easy and many times their attending physician must seek help from multiple subspecialists. This, of course make their care and evaluation more expensive, but the Medicare patient is entitled to the same diligence in the evaluation of his illness as the private-pay patient.

As a practicing internist, I see many patients who are Medicare recipients. I endeavor to be as meticulous in my workup of these patients as with any other patient.

The DRG system threatens this type of care and it is my hope that through these hearings this Special Committee on Aging will see that the health care of every senior citizen in this country is jeopardized.

Chairman HEINZ. Before I turn to Senator Warner who is also a very active member of this committee, let me just check one point with our three first witnesses.

Mrs. Mahla, you said that you never received any informaton on your rights or your mother's rights under the DRG system until a couple of weeks after your mother had passed away; is that correct?

Mrs. MAHLA. I never received any rights until a week-and-a-half ago, 2 months after she died.

Chairman HEINZ. Two months after she died.

Mrs. MAHLA. I did not know we had an appeal.

Chairman HEINZ. And at no point were you ever informed that you could appeal the discharge decision.

Mrs. MAHLA. Not once.

Chairman HEINZ. Were you ever informed that you could appeal the discharge decision, Mrs. Buttrill?

Mrs. BUTTRILL. No; we were told that the head of the DRG in Richmond sent these guidelines down and that was it.

Chairman HEINZ. Well, as you have both now learned, it is a fact that there is a right of appeal of a discharge decision and that that is a right that everybody has under the DRG system, and that you should have been informed of these rights. But, as a result of your not being informed, you were deprived, and most importantly, your mothers were deprived of their legal rights.

And I gather, Mrs. Kratt, you were not informed of your right or your mother's right to appeal the decision of the discharge. Is that correct?

Mrs. KRATT. The first I knew of it was when I received that letter, and it was after she had passed away. The letter was addressed to my mother. It was not addressed to me, but I opened it up, and then it was all in there about how I could appeal.

Chairman **Heinz**. And the letter explaining all that was received when?

Mrs. **Kratt**. After she had passed away.

Chairman **Heinz**. It does not do a lot of good then, does it.

Mrs. **Kratt**. They wrote it on the 29th, and then she passed away a few days later.

Chairman **Heinz**. Well, I must tell you, each of you is to be commended on coming here and testifying. I know it is not easy. In the first place, it is hard to testify about the difficulties you have had with a loved one; second, you have got some very tough things to say about what is taking place in this country today.

I wish I could say that you were the only three people in the country who have had these kinds of experiences, but I suspect you know that you are not, by any means, unique. It is happening across the country.

I want to call on Senator Warner of Virginia, who has taken a very great interest in the activities of our Aging Committee. I cannot think of a hearing he has not participated in, and, as always, it is a pleasure to have him with us. Senator John Warner of Virginia.

STATEMENT BY SENATOR JOHN W. WARNER

Senator **Warner**. Thank you very much, Mr. Chairman.

I can speak from some personal experience. I have a mother that is 98 years old, and I am responsible for her care. Fortunately, up until just a little while ago, we had good luck. But my question is as follows, Doctor: This whole situation, the DRG, was brought on because of the national deficit, and that, too, in various ways inflicts hardships on the elderly and others.

What suggestions would you have as to how we can bring into a, shall we say, closer balance the obligation that all of us want to fulfill for quality patient care and at the same time effect some cost control which was the situation preceding DRG with runaway costs in the Medicare Program because of the open-ended reimbursement situation?

Dr. **Kellawan**. Do you want some suggestions I have?

Senator **Warner**. Yes.

Dr. **Kellawan**. Well, I will begin by saying that it is very difficult to control something that is improving all the time. Medical technology has just boomeranged. But I have some ideas, and I am going to mention this term, "the cost of defensive care" for this country.

Senator **Warner**. What was the word?

Dr. **Kellawan**. Defensive.

Senator **Warner**. Defensive.

Dr. **Kellawan**. That the cost of defensive medicine, the cost that is brought about by the fear of malpractice litigation by physicians—failure to do a test, and this has been very well documented. I think the New England Journal of Medicine has had several articles in this regard. And it is estimated that this costs about $20 billion a year. Now, how much of this is due to Medicare, how much *is due to Medicaid, I do not know. But this is very, very significant*—especially in California.

I mean, we live, as physicians, with this all the time. I have been a physician since 1959, and I practiced 11 years in Michigan and then moved to California. I was never sued in Michigan, but I have a suit now pending in California. It is not a big one, but I ought to win it.

But I think this is one item——

Senator **Warner**. So it is the rising cost of malpractice, be it in the insurance premiums that you have to pay or the——

Dr. **Kellawan**. The insurance premium, the hospital has to pay a premium.

Senator **Warner**. That is driving the physicians to do a lot of things that are at variance with their own professional discretion; they would not do them otherwise because they, as professional persons, judge them as unnecessary. But to protect against this contingency, they go on ahead in performing these various tasks which compile or result in a great deal of added medical costs.

Dr. **Kellawan**. I want to tell you something that when the Medicare system went into effect in 1966, they did not have coronary artery bypass. This is medical progress, but it is a very expensive procedure. And I have patients in their seventies who have had bypasses, prolonged their life, prevented angina, made the quality of life better, but this costs money.

Another point I would like to make, Senator, under the Medicare system—I am a participating physician. I signed the slip. I participated before, but on a selective basis. There are a lot of patients who I see who have more money than I will ever see. I think that I am entitled to collect my fee from them, my full fee. Under this system, I could not charge the millionaire farmer in Bakersfield any more money. And those are the guys who take up your time. You know, when they see you in your office, they think they own you, and they are asking about every drug they use, sometimes there are five, six drugs, and yet I collect the same $18.40 for an office call from him as I get from the welfare recipient. And I think that is unfair.

Senator **Warner**. You make a good point. My father was a physician back in the 1930's and he used to take care of many indigent persons, but he also had a number of affluent, and he always used to say that the affluent took care of the indigent.

[The prepared statement of Senator Warner follows:]

PREPARED STATEMENT OF SENATOR JOHN WARNER

Mr. Chairman, I commend you for having initiated this forum on the standards of health care delivery under the medicare prospective payment system.

We have heard much of the economic and statistical gains resulting from the implementation of DRG's.

Medicare, the Nation's principal old age hospitalization insurance program, has led the way in the dramatic reduction in health care price inflation.

There has been a significant decrease in actual hospitalization insurance utilization, premium growth has stabilized, and indeed, in some cases premium costs are actually being reduced.

What is the other side of this coin, however?

I believe that is why we are here today, to begin an intensive review into the quality of health care now available to medicare beneficiaries.

There are some 29 million elderly and disabled citizens now eligible for medicare, and it is our responsibility to assure that they may continue to rely on these benefits.

From an initial review of the aging committee staff report of this date, it appears that the medicare prospective payment system is in great need of reform.

Medicare patients are being denied hospital admission unless a rigid standard of illness is met;

Inpatient care is suffereing because of reduced staffing levels and the intensity of illness;

Multiple ills so often evident in older patients are not reflected in current DRG standards.

And lastly, medicare patients are being released as rapidly as possible with a significant burden placed on the nation's nursing homes and home health care programs, many without facilities to provide needed care.

Mr. Chairman, these are symptoms of a malady which must be treated.

Congress created medicare DRG's to help slow the enormous growth of the program, but it was no one's intention to exact a penalty from beneficiaries.

Starting with the testimony we will hear today, I am hopeful that we can begin a constructive cure of medicare's ills.

Chairman HEINZ. Senator, I want to thank you very much.

One last question for Dr. Kellawan is this: If you were to make one or two major recommendations how Congress, if it was going to keep the prospective payment system, DRG's, but wanted to improve the quality of care and avoid the kinds of problems that have been testified to by both you and our other witnesses here today, what one or two changes would be the most important to make?

Dr. KELLAWAN. Everybody, every human being has to be—they cannot be pigeonholed. DRG with modifications for age, the type of illness, and other complicating factors.

Chairman HEINZ. Are you familiar with the Johns Hopkins methodology?

Dr. KELLAWAN. No, I am not.

Chairman HEINZ. They have a system similar, I believe, to what you are describing?

Dr. KELLAWAN. No. 2 is that we have to educate, I think that has begun, especially Medicare recipients, everyone has to live—I think life is only meaningful if it is of good quality And I think if you are going to cut down on a major problem in this country, maybe I am biased because I do not smoke, we have to get to all the citizens who get pulmonary emphysema, who have coronary artery disease or diabetics, to quit smoking. That might sound simple, but it would have a major impact on the cost of medical care in this country.

Chairman HEINZ. Let me ask one last question, which is do you think the peer review organizations can be helpful in a sense strengthening the will of physicians to do what they think is right and preventing hospital administrators from creating situations where people are being hurt when they should not be hurt?

Dr. KELLAWAN. Peer review organizations for hospitals is fine; for physicians, no. I really mean that.

Chairman HEINZ. What I am asking is, Can the mission of the peer review organizations be changed so they can in fact cause the dynamics I have just described in order to improve the system? It is my sense that physicians are doing things that they do not want to do or they know they should not do and that hospital administrators and others in hospitals are pressuring them to do those things. Is there a way that we can modify the role of the peer review organizations, which were created with this very same concern in mind, to safeguard against some potentially very serious problems under DRG's?

Dr. **Kellawan**. Well, it certainly would need changing a lot. In my experience, peer review has been a weight on my neck, and I do not think it has changed my practice of medicine.

Chairman **Heinz**. Very well.

Well, let me thank all of you for being here. I very much appreciate everything that you have contributed to this committee today.

Senator **Warner**. Mr. Chairman, I would like to recognize the presence of one of my constituents, Mrs. Buttrill, and I understand some Members of the Congress here, the delegations were of assistance in your case.

Chairman **Heinz**. Very well.

Mrs. **Buttrill**. Yes. Thank you, Senator.

Chairman **Heinz**. Thank you all very, very much.

While our next panel is coming forward, I would like to recognize Senator Burdick of North Dakota for any statement that he cares to make.

Senator **Burdick**. No statement, Mr. Chairman.

Chairman **Heinz**. All right.

While our witnesses are coming up, I want to enter into the record at the appropriate point a letter that I have received from the American Hospital Association, dated September 26, signed by Jack W. Owen, executive vice president, on the subject of this hearing.

[The letter referred to follows:]

American Hospital Association

AHA

444 North Capitol Street N.W.
Suite 500
Washington D.C. 20001
Telephone 202.638.1100
Cable Address: Amerhosp

September 26, 1985

Honorable John Heinz
United States Senate
277 Senate Russell Office Building
Washington, DC 20510

Dear Senator Heinz

The Medicare prospective pricing system was created by Congress, with the support of the hospital industry, in an effort to create a positive incentive to increase the efficiency with which hospital services are produced and used. The success of prospective pricing in containing costs has been amply documented. However, a shorter average length of stay and declining admissions have caused some to raise questions concerning the effect of prospective pricing on quality.

The American Hospital Association believes that hospitals are making a good-faith effort to continue providing access to high quality medical care while living within the constraints imposed by the prospective pricing system. Although the system is based on averages, the only factors that should affect the care a patient receives are the patient's needs and the capabilities of the hospital in which the patient is treated. Hospitals have an obligation to provide the care their Medicare patients need, regardless of the average price established by the prospective pricing system. Congress, in turn, has an obligation to see that the level of prices and overall design of the payment system do not penalize hospitals for meeting their obligations to their Medicare patients.

There is no evidence that prospective pricing has caused a widespread erosion of quality. A single instance, or even a handful of instances, of poor quality care does not prove that the prospective pricing system is fatally flawed or that the entire industry is adopting practices that jeopardize the quality of care available to Medicare beneficiaries. Nor can the unsystematic reporting of such cases substitute for an efficient and effective system of medical peer review. Any instance of inadequate care is, however, cause for concern. It always has been and always should be. Such cases call attention to the need to monitor the Medicare payment system and the Peer Review Organization program to identify and correct flaws in their design that may jeopardize quality.

Growing concern about the effect of prospective pricing on quality of care is of immediate interest to beneficiaries and providers, as well as the public, the Administration, and members of Congress. Medicare beneficiaries must be assured that prospective pricing will not impair quality and that post-hospital care will be both available and adequately covered by Medicare.

AHA is firmly committed to achieving the goal of the prospective pricing system: greater efficiency in the delivery of high quality hospital care. To make sure that this goal is achieved, AHA is prepared to work with members of Congress, the Administration, beneficiary groups, and other providers to identify problems with the design of the prospective pricing system and the current methods of medical review and monitoring.

As a first step, I would like to invite staff of the Select Committee on Aging, staff of organizations representing beneficiaries, physicians, and other providers, and representatives of the Health Care Financing Administration, to meet with AHA staff to more clearly define the possible nature, extent, and causes of any problems experienced by Medicare beneficiaries. We particularly are interested in assessing how best to modify the system to ensure the availability of services to patients with above-average needs. In addition, at least part of the problem may be the inadequacy of the information available to Medicare beneficiaries describing benefits and payment policies, including the right of beneficiaries to review of coverage decisions.

The questions that have been raised, and the accusations of deteriorating quality, must be answered. If the concerns are unjustified or can be resolved easily by a fine-tuning of the payment and peer review systems, Medicare beneficiaries should be reassured that the new policies do not pose a threat to their ability to obtain the high quality medical care they need. If more fundamental changes are needed, they should be identified and implemented before public confidence in the Medicare program and providers is irreparably--and needlessly--harmed.

Sincerely

Jack W. Owen
Executive Vice President

Chairman HEINZ. While our witnesses are coming forward, I will just make the observation that the panel that we are about to hear from consists of health care providers and a researcher. Dr. James Hunter is a practicing physician and chairman of the utilization review committee at a North Carolina hospital; accompanying him is the president of that same hospital, Mr. Perry Jones.

Dr. Edward McKenzie is a practicing general surgeon at a second hospital in North Carolina, and Ms. Barbara Jones is a registered nurse and home health coordinator for a North Carolina county health department.

We will also hear from Dr. Sigmund Greenberg, a practicing internist in my Home state of Pennsylvania, a constituent. I am very pleased, Dr. Greenberg, that you could be here. And from Dr. David Brodsky, Ph.D., a professor at the University of Tennessee at Chattanooga.

On behalf of the committee, I want to welcome all of you and thank you for taking the time out of your busy schedules to help us identify and correct some of the problems with quality care in our Nation's hospitals, and in the interest of saving some time, because some of you have some rather lengthy prepared statements, all of which will be made a part of the record in their entirety, I would ask you to summarize your statements and I would also think it would be helpful if we as the committee would refrain from asking questions until after all statements have been presented.

So, Dr. Hunter, would you please proceed.

STATEMENT OF DR. JAMES HUNTER, CHAIRMAN, HOSPITAL UTILIZATION REVIEW COMMITTEE, ACCOMPANIED BY PERRY JONES, HOSPITAL PRESIDENT

Dr. HUNTER. Mr. Chairman, I appreciate the opportunity to be here today.

DRG's or the prospective payment system, as it is known, is a very unique system which I think has some strong points. On the other hand, it has some very deleterious effects on certain patients and, thus, on the hospitals that provide care for them. Patients are being denied care because of two reasons: One, unrealistic admission criteria, and two, premature discharge. Patients who are being denied appropriate care are the elderly and the chronically ill. As long as the current system exists in its present form, the problem will worsen.

If I see a chronically ill Medicare patient in the office and judge this patient to be sick enough to warrant hospitalization, I then have to turn to the DRG handbook. After all those years of medical school and many books, it is all contained in this little blue book. And if I could find the right criteria in this little blue book, I can admit the patient to the hospital.

Not only do I have to follow the criteria in the book to admit the patient, but then to make matters worse, I have to order certain treatments such as intravenous antibiotics in order to justify the patient remaining in the hospital.

All this must be done even though I, having practiced internal medicine for 20 years, know that my patient is sick enough to warrant hospitalization.

We are really powerless to admit patients that common sense and compassion dictate belong in the hospital. An 82-year-old woman with breast cancer, metastatic to her spine who is at home in severe pain cannot be admitted to the hospital unless we can justify certain criteria for treatment. Both her family and she desire admission to our local hospital, but this cannot be done unless orders are written for intramuscular injection of pain medication at least three times daily.

If we are fortunate enough to get a patient into the hospital, then the patient's chart is retrospectively reviewed months later by a review organization that is funded by the Federal Government through HCFA. If my hospital has 2½ percent of admissions or three cases in a 3-month period that are judged by the review organization not to warrant admission, my hospital loses its waiver of liability. This happens even before the appeal process is completed. But once the waiver is lost, all Medicare admissions are reviewed. Now, these original three cases that resulted in the loss of waiver could eventually be reversed, but in the meantime, the hospital has been on 100 percent review and the review organization finds more cases that they think are not justified admissions. The system snowballs and my hospital faces even potentially more damaging action; they could eventually lose the right to receive payment for Medicare patients.

During the months under the DRG system, my hospital has encountered such an experience. I consider that I practice in an excellent community hospital with a highly qualified concerned medical staff, yet we are in trouble because we have been placed on 100 percent review.

I serve as the chairman of the utilization review committee in my hospital, and this committee has reviewed 92 percent of the denials that have been issued by the review organization in 1985. In 24 percent of the cases we have agreed with them that the admission was not indicated. However, in the other 76 percent we have disagreed with the reviewer. Personally, we do not think that the review criteria are realistic. We feel that the guidelines given the PRO by HCFA are unrealistic and are set up to save money and not, as HCFA likes to advertise, to improve quality of care.

Actually, all that we are doing is rationing health care and there is nothing in the present act that is going to improve the quality of care.

The perception from our community is that the PRO system provides a regional rubber stamp for HCFA policies and administrative rulings. Rather than serving as a patient advocate to actively ensure good medicine and lower costs, the PRO system seems mired in the bureaucratic process. The quality of care is not, in my opinion, enhanced.

The emphasis of the PRO and the DRG system to date has been so far removed from quality of care as to cause many to believe that the Federal Government is not interested.

We do not think that the PRO's understand their role because we do not think that HCFA has defined that role. It is unfair to have such a ridiculous denial rate as ½ percent trigger 100 percent review, and it is not fair to penalize a hospital for cases that have not completed the appeal process. The appeal process uses up valuable physician time that could be used for patient care.

I estimate that I have to spend 1 to 1½ hours reviewing each of my cases that is denied in order to appeal the denial. I also resent the fact that I spend 3 to 4 hours each month discussing all this with staff, with physicians, DRG coordinators, and other interested people. None of this concerns quality of care; it is simply busy work promulgated by a system that is ill-conceived and is not working.

What would I do? I would establish more realistic numbers for denials and loss of waiver. And I would allow completion of the appeal process before taking action against the hospital. Medicine is an art and not a science. It cannot be practiced out of the DRG handbook. HCFA should give more power to the local hospital and let the utilization review committee turn to the PRO with problems they cannot handle. The PRO could easily monitor the effectiveness of the hospital committee. Our medical staff can handle this situation in a far more realistic manner than can the PRO through HCFA guidelines, and thus we can continue to provide the quality of care that we have always provided in our community hospital.

[The prepared statement of Dr. Hunter follows:]

Prepared Statement of James E. Hunter, M.D.

DRGs or the Prospective Payment System, is a unique system which has some strong points. On the other hand, the system has deleterious effects on certain patients and thus on the hospitals that provide care for them. Patients are being denied care because of two reasons: (1) unealistic admission criteria; (2) premature discharge. The patients who are being denied appropriate care are the elderly and chronically ill. As long as the current system exists the problem will worsen.

If I see a chronically ill Medicare patient in the office and judge this patient to be sick enough to warrant hospitalization, I then have to turn to the DRG handbook to make certain that I can justify this patient's admission useing *their* criteria for severity if illness. And to make matters worse, I have to order certain treatments like I.V. Antibiotics in order to satisfy intensity of service criteria. All of this must be done even though I, having practiced Internal Medicine for 20 years, know that my patient is sick enough to warrant admission.

We are powerless to admit patients that common sense and compassion dictate belong in the hospital. An 82 year old woman with breast cancer, metastatic to her spine lies at home in severe, but intermittent, pain with all of the systemic problems associated with a malignancy. Both her family and she desire admission to our local hospital, but this cannlot be unless orders are written for intramuscular injection of pain relievers at least three times daily, medication she may not need that often.

Patients charts are retrospectively reviewed months later by a review organization funded by the Federal Government through HCFA. If my hospital has 2.5% of admissions or 3 cases in a 3 month period that are judged by the reviewer not to warrant admission, my hospital loses its waiver of liability. This even happens before the appeal process is completed. Once the waiver is lost, all Medicare admissions are reviewed. Now those 3 cases could eventually be reversed but in the meantime on 100% review, the review organization finds more cases that they think are not justified admissions. This system snowballs and my hospital faces more potentially damaging action—they could lose the right to receive payment for Medicare patients.

During the months under the DRG system my hospital has encountered such an experience. I consider that I practice in an excellent community hospital with a highly qualified, concerned medical staff; yet we are in trouble. We have been placed on 100% review.

I serve as chairman of the Utilization Review Committee in my hospital and this committee has reviewed 92.6% of the denials issued by the review organization in 1985. In 24% of the cases we have agreed with them that admission was not indicated. However, in the other 76% we have disagreed with the reviewer. We don't think that the review criteria are realistic. We feel that the guidelines given the PRO by

HCFA are unrealistic and are set up to save money and not as HCFA likes to advertise, "to improve Quality of Care."

The perception from our community is that the PRO system provides a regional rubber stamp for HCFA policies and administrative rulings. Rather than serving as a patient advocate to actively insure good medicine and lower costs, the PRO system seems mired in the bureaucratic process. The quality of care is not, in my opinion, enhanced.

The emphasis of the PRO/DRG system to date has been so far removed from quality of care as to casue many to believe that the federal government is not interested.

We don't think that the PROs understand their role because we don't think that HCFA has defined that role. It is unfair to have such a ridiculously low denial rate as 2.5% trigger 100 percent review, and it is not fair to penalize a hospital for cases that have not completed the appeal process. The appeal process uses up valuable physician time that could be used for patient care for I estimate that I have to spend 1 to 1½ hours reviewing each of my cases that is denied in order to appeal the denial. I also resent the fact that I spend 3 to 4 hours each month discussing all of this with staff, physicians, DRG coordinators, etc. None of this concerns quality of care—it is simply busy work promulgated by a system that is ill conceived and is not working.

What would I do? I would establish more realistic numbers for denials and loss of waiver. And I would also allow completion of the appeal process before taking action against the hospital. Medicine is an art and not a science. It can not be practiced out of a DRG handbook. HCFA should give more power to the local hospital and let the Utilization Review Committee turn to the PRO with problems they can not handle. The PRO could easily monitor the effectiveness of the hospital committee. Our medical staff can handle this situation in a far more realistic manner than can the PRO through HCFA guidelines, and thus continue to provide quality of care.

[Subsequent to the hearing the following statements of Perry T. Jones and Thomas H. Byrnes, M.D., were received for the record:]

Prepared Statement of Perry T. Jones

I appreciate the opportunity to share our hospital's experience with the Prospective Payment Systems (PPS). In the past two years, Hospital's inpatient admissions are down from 5,400 to 4,440 per year. The average length of inpatient stay has decreased from 7.5 days to 6.3 days. As a result, we have closed a patient wing on one floor and eliminated 35 jobs hospital-wide. Our outpatient surgery has increased 5%. One registered nurse reviewer and a secretary have been added in the past 6 months in an effort to eliminate denials of admissions. The cost of these employees is $40,000 per year.

Our percentage of reimbursement dollars received in relation to our regular charges has improved approximately 10%. This certainly is a positive step and one for which we are very appreciative. Even with this improvement, our final reimbursement is only approximately 73¢ per $1.00 of charges.

The impact of PPS on the quality of care has been dramatic. Our average patient is sicker at the time of admission and stays a shorter period of time as an inpatient. This applies to the total hospital population and not just Medicare patients. The intensity of nursing service throughout the hospital is consequently much higher now than in past years. Because patients are being discharged earlier, the home health agencies are having to respond to significantly increased patient loads.

Physician behavior is altered due to considerable concern over denials of admission, leading to being put on some sort of Government "black list". Families and patients receiving notices of denials become upset, feeling that either their physician is somehow inadequate or that they have been taken advantage of by the system.

It is my feeling that the Federal government's efforts to educate the general public concerning Prospective Payment was extremely inadequate. Education of physicians was left pretty much to hospitals and Peer Review Organizations and was spotty at best. I believe hospitals received the information, but unfortunately due to the evolving nature of the program, much of the information was either incorrect, changed at a later date, or misinterpreted by one or more levels of the system prior to dissemination to hospital.

I believe that the Medical Review of North Carolina and our state and local review organizations, have done the best they possibly can under an inadequate system. I know for a fact that in our institution the reviewers cannot possibly complete an adequate job of reviewing the large number of charts which they are forced to review each month. I am a firm believer in the free enterprise system, but the use of review organizations following the instruction of H.C.F.A., which in turn is following the instructions of the Congress and the Executive Branch, has too many layers requiring too much communication, the net result of which is that the patient who is on the very bottom of this deep bureaucracy becomes the loser. The system is too impersonal and the individual making the ultimate decision is too far removed from the patient and his/her condition.

It is obvious to anyone who has given much thought to the matter, that the name of the game is ration healthcare to the elderly and disabled. The Congress should convene a Blue Ribbon Committee made up of ethicists, physicians, philosophers, economists, the clergy and legislators to face squarely the question of rationing of healthcare dollars. I realize that this is a potentially unpopular undertaking and deserves much study and adequate time for resolution.

While this process is going on, I for one would prefer to eliminate review organizations per se and have placed in my institution a government paid nurse reviewer whose job it would be to review all Medicare cases admitted and all cases for which admission is requested. This person could be backed up by a regional physician on appeal and a panel of specialists for final decision-making for cases requiring an additional level of review. In this way, most decisions concerning admission to the hospital and payment for same would be made on a totally local level with the best input concerning the patient and his or her medical and social conditions. Such a nurse reviewer could deal directly with H.C.F.A. for continuing updates of the criteria for inpatient admissions. Additionally, a massive public education program should be undertaken in an attempt to alleviate the misunderstandings concerning the operation of Prospective Payment and the impact on all involved.

In summary, I would like to say that I feel the Prospective Payment System is workable. I think it puts off the ultimate questions of rationing only temporarily, however. The effort which you and your committee is making to identify and rectify the problems with the administration of the system has long been needed and is much appreciated. For the sake of all involved I wish you well in the endeavor.

PREPARED STATEMENT OF THOMAS H. BYRNES, M.D.

The Prospective Payment System (DRG System may well save money but is very poorly administered and grossly unfair as it is now structured. There's not only an effort to set fixed cost per illness but a sudden and oppressive attempt to set unfair criteria for admission.

Who Pays the Price?—The Medicare beneficiary who is denied fundamental medical insurance. They no longer are assured admission coverage for potentially serious or painful illnesses or injuries. The hospital cannot afford to encourage admissions in cases where arbitrary retrospective review may lead to denial of payment and the additional risk of potential sanctions or other penalties on the hospital. This system promotes the unavoidable effort on the part of the hospital to discourage any but the most obviously indicated admissions. This inevitably causes the Medicare beneficiary to suffer unnecessary pain or risk of bad results in those cases which would be considered borderline under the current regulations.

Who Else Suffers?—The physician who now must view every encounter with the Medicare patient as a "no win" situation. If a patient is not admitted, there is concern of having erred out of fear of denial with resultant harm to the patient and possible professional liability. To admit the patient is to fear denial of the claim with resultant negative pressure from the hospital or the patient or his family. Professional judgment is imparied unavoidably by this situation. Even the most competent and qualified physician cannot avoid being unduly influenced by the pressure.

Who Else Pays the Price?—The hospital that risks loss of revenue plus alienation of the Medicare recipient and physicians. There is caused shifting to the non-medicare patients which is clearly unfair as well.

Who Pays No Price?—Why, the Medicare Program which has shifted all blame to the hospitals or physicians. Medicare now seems to feel no obligation to the people whom it is charged to serve. It hides behind a facade of "saving money by improving quality of care and avoiding excessive hospital utilization." The previous PSRO Program, where it was properly implemented, revealed only modest over-utilization and confirmed that Medicare recipients were receiving exceptionally good medical care. The over-utilization problems were largely corrected before the DRG Program began. The DRG Program with its unreasonably low quotes and arbitrary criteria is a grossly unfair attempt to ration care to the elderly. Perhaps we must ration care, but if so, we must find a more equitable system.

Chairman HEINZ. Dr. Hunter, thank you very much.

Dr. McKenzie.

STATEMENT OF DR. EDWARD McKENZIE, GENERAL SURGEON

Dr. McKENZIE. Thank you, sir.

The recently proposed Prospective Payment System, DRG's, and especially the Professional Review Organizations, threaten to deny safe health care——

Chairman HEINZ. Dr. McKenzie, could you pull that microphone just a little closer so everyone can hear you?

Dr. McKENZIE. Is that all right now?

Chairman HEINZ. Well, say something.

Dr. McKENZIE. All right. [Laughter.]

The recently imposed Prospective Payment System——

Chairman HEINZ. A little bit closer. I am sorry.

Dr. McKENZIE. I hope I do not hurt your ears.

And especially the Professional Review Organizations threaten to deny safe health care to a substantial segment of our population. Doctors are being forced into health decisions based on rigid Federal guidelines. The doctor is caught in a terrible dilemma, wanting to provide high-quality safe care but concerned that hospital care will be denied by some distant, anonymous source and that he might thereby contribute to the financial burden of his hospital, even to its bankruptcy.

Added to that conflict is the ominous threat of malpractice that hangs over every medical decision. Rigid guidelines seem to increase that risk. Appeals can be made for the reversal of a denial, but this is so long and so frustrating that the doctor soon feels intimidated and harassed into submission. The guideline for an operation that can be performed as an outpatient under proper circumstances becomes an absolute rule, that all such operations must be performed as an outpatient regardless of the special needs of the particular patient.

The patients who suffer the most are the oldest, the poorest, the sickest, and those who live alone. Several cases illustrate these points. A fellow surgeon commented that after denial of four consecutive cases of a particular type, he no longer tries to admit such patients regardless of the circumstances.

In another case, a highly respected gynecologist performed an operation on an obese, hypertensive, quite elderly, diabetic female who lived alone. Her hospital admission was denied through several stages of appeal because the guidelines state that such an operation can be performed as an outpatient.

In another case, a urology patient was admitted to the hospital and had a bladder tumor burned out by electric cautery. She was discharged in 3 days, but after 3 more days she had to be readmitted because of bleeding. The first admission was denied because the guidelines indicated admission was not necessary. The second admission was denied because the patient was discharged too soon from the first admission.

Another patient, found to have hopeless cancer of the lung, died at home 3 days before the family received a computerized notification that her recent hospitalization was unnecessary.

One suggestion for a better system is preadmission screening for all Medicare hospitalizations. Our 300-bed hospital is now doing this with only one secretary. Let that be done nationwide, and where the guidelines are in conflict with the planned admission, let a second local opinion be obtained.

Finally, there appears to be a conflict of interest in paying rather high salaries to volunteer physicians to investigate Medicare cases for the government, knowing that the job depends on a rather high rate of denial. It seems reasonable to require all physicians who treat Medicare patients to serve on review panels at little or no compensation, but doctors who do not treat the elderly should not be part of the review system.

[The prepared statement of Dr. McKenzie follows:]

PREPARED STATEMENT OF EDWARD B. MCKENZIE, M.D.

I am a general surgeon in a small town in west-central North Carolina, where I have lived and worked for 29 years. Until very recently, working through a community hospital, we were able to provide good quality medical care for our elderly. Medicare was a positive step in fact toward insuring continuity in health care for the aged. Now as a result of the recently imposed Prospective Payment System, the DRGs, and the Professional Review Organizations, we face the prospect of denial of decent health care to a substantial segment of our older population.

Doctors are being forced into decisions with regard to the kind of care they will give and when and where they will give it by rigid and unreasonable federal guidelines enforced anonymously from outside the community. The doctor is caught between trying to provide proper medical care and the prospect that a faceless reviewer to whom there is no practical appeal will deny payment to the hospital and thereby penalize the community and added to that is the looming threat of a malpractice suit and the fact that the regulations do not provide for the best possible care. They in fact make such lawsuits more likely and therefore discourage some of us from wanting to treat Medicare patients.

The idea that the quality of health care can be improved by reducing hospitalizations or by decreasing length of stay is difficult to accept. The fact that another doctor looking at a copy of the chart can say he might have done things differently is interesting, but really not much more than a difference of opinion. It has nothing to do with whether or not the patient got good or poor care. It seems that the pressure is on to get the review organizations to criticize and deny payment on a certain number of admissions no matter what the merits might be. If the number of denials is not sufficient, the pressure from Washington increases.

I support the idea of same day surgery and increased use of outpatient surgery generally as means of controlling costs and even in some cases improving care. The regulations as applied, however, seem to prescribe this same "cure" for surgical costs to all patients, regardless of age, or health, or ability to care for themselves or their wounds, and this is unreasonable. If a doctor doesn't follow these rules the hospital is denied payment, that is to say, the hospital gets a denial letter.

Denials lead to a series of letters called appeals which are reviewed by a physician (on a rather handsome government salary) who anonymously and usually routinely rejects the appeal via a computerized form letter. If the doctor persists with determination, a personal confrontation can be arranged and the vague possibility exists for an overturn of that denial. Even if the doctor wins such an appeal, after many hours of frustration and considerable expense, how many more appeals will he make in future cases? Not many. Eventually even the most determined and conscientious will give up and guidelines will prevail and the special circumstances will not longer matter. The doctor will either refuse to treat the patient or he will treat her in a manner he considers unwise and unsafe.

Several cases illustrate these points. A fellow surgeon commented that after the denial of four consecutive cases of a particular type, he no longer tries to admit any such cases regardless of the circumstances. A highly respected gynecologist performed an operation called a cold knife conization on an obese, hypertensive, quite elderly, diabetic female who lived alone and who had several other complicating factors. Her admission has been denied through several stages because the guidelines state that the operation of a cold knife conization can be done as an out patient. This doctor feels that under the circumstances that existed, it should never be done as an out patient.

The third case was a lady with cancer of the lung who was found to be inoperable after bronchoscopy. Her family received her computer print out anonymous denial notice three days after she died. They were not pleased. Neither this committee nor the Department of Health and Human Services is concerned with medical malpractice but, for a brief moment, consider that doctor's dilemma if he had already succumbed to the harassment and intimidation of the reviewers and he had not admitted that patient although he thought she should be admitted and she then died after her bronchoscopy.

Finally consider the case of a 71 year old obese hypertensive female with very large breasts. She lived alone under conditions thought to be poor and of uncertain sanitation. She presented with a very large mass in the right breast with bloody drainage from the nipple. She had had a mass removed from the same area several years earlier as an inpatient. Pathology at that time revealed a benign condition called fat necrosis with an abscess. Because the patient was so obese and her breasts and the mass so large, because there seemed danger of a flare up of past infection, because the patient lived alone and could not care for the wound, because it was estimated that the patient lived in poverty and possible unsanitary conditions, because of these considerations, hospitalization was recommended. The operation was carried out in the hospital and recovery was uneventful. The patient was in the hospital three days.

Two months and ten days later the first denial was received. Three months later the final denial was issued at what was to be a Board meeting for this case. The Board consisted of a pediatrician and a doctor of foreign extraction who did not communicate well in the English language. The only explanation given was a letter this doctor had written previously. Two sentences are quoted verbatim. They summarized this case and subject. "The guidelines for excision of a benign breast mass are to do as out patient surgery. I hope thay in the future, the attending physician will attempt to follow the guidelines for this type of surgery." (Misspelling as quoted)

That was a personal case of mine. I persisted in appeals for almost six months at the expense of considerable time, energy and frustration. Even if the admission had been proven justified it is doubtful that many more appeals will be made. Harrassment and intimidation, applied anonymously with computers, can do the job.

There are suggestions for a better way to accomplish these savings without the considerable expense this system requires. Our hospital now requires pre-admission certification of all Medicare cases. This requires only one secretary for a 300 bed hospital. If this method were adopted nationwide, it should allow the dismantling of much of this cumbersome, expensive, bureaucratic burden. Further, I see a conflict of interest in paying rather high salaries to physicians to investigate Medicare cases for the government, knowing that the job depends on a high rate of denials. Review of appeals should be done by all physicians who treat Medicare patients, and that service should be required, and it should not be compensated. Doctors who do not treat the elderly should not be part of the review system.

Chairman **Heinz**. Thank you very much, Dr. McKenzie.

We will call on Nurse Jones.

STATEMENT OF BARBARA W. JONES, R.N., LEXINGTON, NC, COORDINATOR IN A COUNTRY HOME HEALTH SERVICE

Ms. **Jones**. Mr. Chairman, thank you for the opportunity to testify before this committee on the effects of the Prospective Payment System——

Chairman **Heinz**. Could you pull your microphone a little closer again, please?

Ms. **Jones**. OK. Thank you for the opportunity to testify before this committee on the effects of the Prospective Payment System on Medicare patients. I am a registered nurse. I first became an RN in 1971——

Senator **Warner**. Let me interrupt a minute.

There are an awful lot of people who really want to hear every word. You have come a long way to work here, now, go a little bit slowly and go right into that mike.

Ms. JONES. OK.

I first became an RN in 1971 and have for the past 7 years served as a coordinator in a county-wide home health service run through the county health department. While the Prospective Payment System has resulted in more efficient use of home care resources, and in increased recognition of the services provided, it is also true that it has resulted in more and sicker patients being released into the community. Often, these patients and their families are not prepared for home care. In times past, many of those we now care for at home might well have been in intensive care units.

With a shorter length of stay and reduced staff in many hospitals, patients are often too sick to respond positively to educational efforts and the nurses too shorthanded to spend the extra time needed. We, too, are pressed for time in the home situation. For example, a recent patient was discharged from the hospital with a terminal illness. He came home with a nasogastric feeding tube, urinary catheter, and receiving continuous oxygen. The family had not been taught how to tube feed him. They had had no instruction in skin care, he did have bedsores, they had had no instructions in catheter care or oxygen safety, either. The home health nurse did her best to instruct the family, but home health care cannot replace 24-hour nursing care in the hospital. She is to return as often as she could.

Patients are often discharged on such short notice that necessary medical equipment is not obtained before the patient gets home. Likewise, patients are often sent into unknown or very questionable home situations. Physicians and hospital staff apparently do not have the time to check out the situation before discharge. It is very frustrating for the home health staff to have to watch these patients deteriorate in these circumstances. The patient must deteriorate significantly before readmission can be obtained. With nursing home beds at 87 to 100 percent occupancy and with nursing homes taking Medicaid patients discharged from the hospital preferentially, it is virtually impossible to get a home-bound sick patient admitted to a nursing bed. For example, a retarded diabetic patient was sent home to care for herself. After several days, the home health nurse found that the patient had probably not eaten and that her diabetes was out of control.

A specific case of this inappropriate discharge that we find bothersome is the very elderly patient sent home to a very elderly spouse. For example, an 82-year-old woman fell and broke her back. She was discharged to home, was bedridden, had lost control of her bodily functions, and was mentally confused. The caregiver was to be her 92-year-old husband. Even with the help of a part-time sitter, the husband's health began to fail and the wife finally was placed in a nursing home.

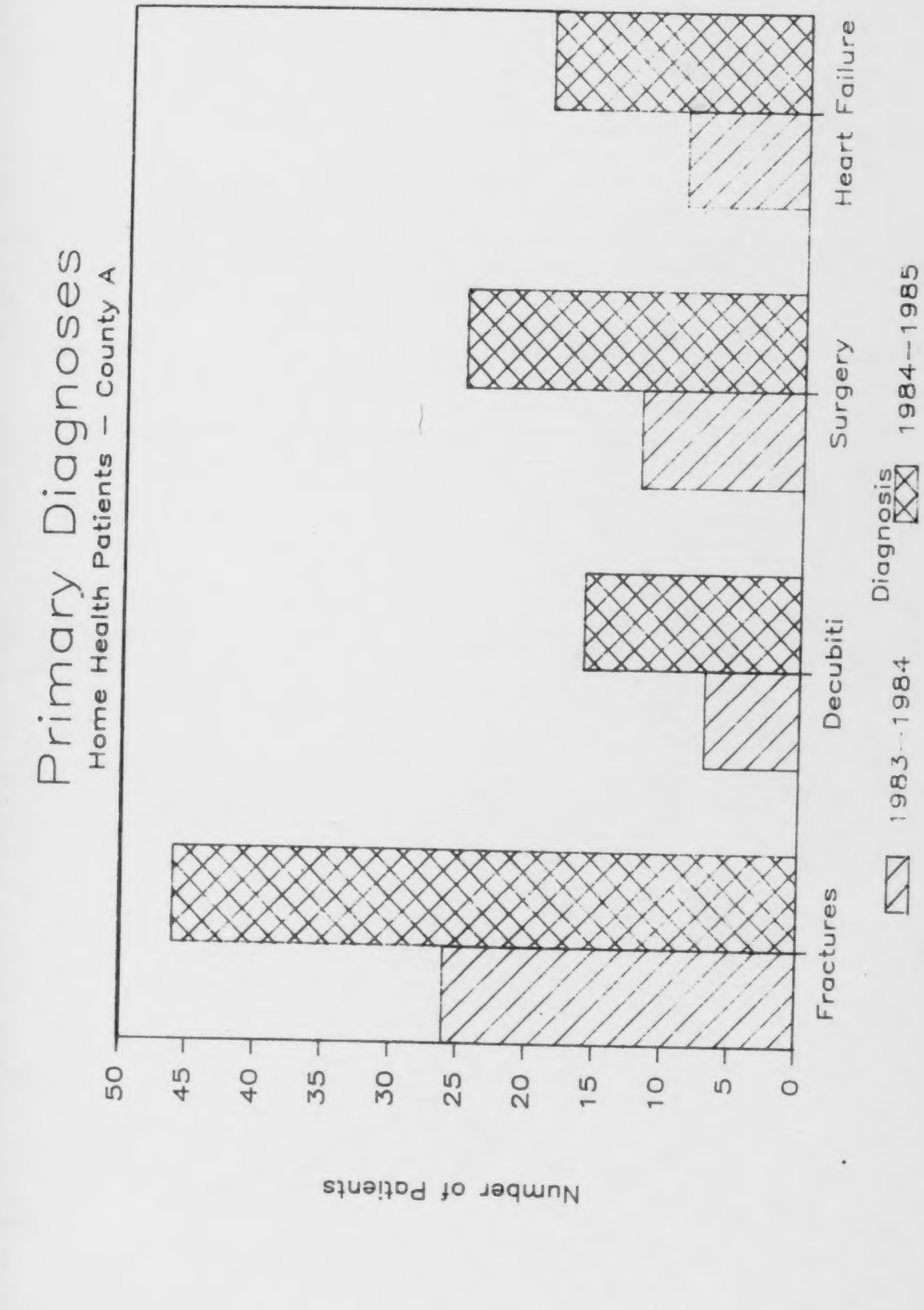
Even when family support is present, sometimes the severity of the patient's illness is overwhelming. One patient, for example, had a tracheostomy, was on a respirator, and needed frequent suctioning and chest physical therapy to prevent pneumonia. In short, he needed total care.

Despite the fact that hospitals are discharging more and sicker patients to their homes, Medicare does not recognize the limits of what can be done to care for these patients in their homes. Home health nurses are being asked to perform potentially unsafe procedures in the home setting. Intravenous antibiotics and chemotherapy, for example, are being given in the home without adequate safeguard in the event of an allergic reaction.

Home health nurses face a dilemma. Morally, they cannot refuse to provide services ordered and needed, but they sometimes do so knowing that it may not be safe. Patients are not getting adequate care and families are being pushed to the point of exhaustion.

The chart here is an indicator of the greater numbers of chronic but very ill patients we are trying to care for. This chart compares 1983-84, the early DRG days, with 1984-1985, the later DRG days. This shows the impact of DRG's over time. As you can see, there has been a dramatic increase in the number of patients we have received in the four diagnostic groupings listed: fractures, decubiti, surgical patients, and patients with heart failure.

[The chart referred to follows:]


Primary Diagnoses
Home Health Patients – County A
Number of Patients
0
5
10
15
20
25
30
35
40
45
50
Fractures
Decubiti
Surgery
Heart Failure
Diagnosis
1983–1984
1984–1985

If this system continues in its present form, with more and more of these patients coming into the home situation, some mechanisms must be developed to permit payment for needed services and to provide general assistance to the families.

Thank you.

Chairman **Heinz**. And as I understand that chart, just to be clear on the record, it fundamentally shows that the number of home health care patients in each of those categories has approximately doubled, in some cases more than doubled.

Ms. **Jones**. Yes, sir.

Chairman **Heinz**. In an area where the population has been relatively stable.

Ms. **Jones**. That is right.

Chairman **Heinz**. Thank you.

Dr. Greenberg.

STATEMENT OF S.R. GREENBERG, M.D., ABINGTON, PA, INTERNIST, ABINGTON HOSPITAL

Dr. **Greenberg**. Mr. Chairman, I am a practicing internist in your home State. I have come here today to speak with you about a crisis in medical care affecting primarily the elderly.

Diagnosis related groups, like so much of what has been tried in the name of cost control, have become a tremendous, and I believe, unreasonable burden. The possible complications and the variations in response to treatment, the great number of things that can interfere with a planned workup in a morbidly ill patient are by no means anticipated by the DRG's. I think, for example, of a patient admitted for diabetes, seemingly complicated by weight loss and poor control. We find in the hospital the patient actually has metastatic cancer of the pancreas and this was causing his diabetes. He had become so run down from his cancer that his heart began to fail; in fact, he finally dies of heart failure. How do you anticipate going into that situation that the diabetic will die of heart failure brought on by malnutrition secondary to an unknown cancer? How could one, in good conscience, send this patient with a chronic, debilitating disease out of the hospital to be evaluated as an outpatient? Put yourself in that man's position, experiencing the pain, sickness, the nausea, the vomiting, weakness associated with the disease process. Imagine having to get out of bed and travel back and forth to the lab every day and to the hospital. And what about the family?

Doctors are coerced into sending patients like this one out of the hospital long before it is medically, morally, or ethically reasonable. They are forced by the cold-blooded use of the so-called Utilization Review Committee. Without regard to the emotional impact on the patient or the family, and without recourse to any appeal process, these people willingly force the discharge of this kind of patient. The hospital feels it is more important to be in the black and in a postive financial state than to try to cure the patient or to make life easier for the family.

Things have reached the point that if enough of the physician's patients cause a deficit in reimbursement to the hospital, he may be threatened with dismissal from the staff, loss of privileges, or else invited to join the staff of another hospital that can, quote, "afford him," unquote. I have great difficulty maintaining the quality of care I am trained to administer because of the constant badgering of the Utilization Review Committee. This is now compounded by the impersonal long distance review of patient records by the doctors hired by the PRO. This kind of review is as incomprehensible to the families involved as it is to me. The idea of the doctor trying to make a decision on the basis of this kind of paper review with regard to how to treat a patient is silly. The long distance practice of medicine based on paper records prepared by someone else is no more reasonable than the retrospective second-guessing of what the doctor did. Would the well-being of the patient be served by a long distance doctor making decisions by telephone, or would it be better served by a doctor on site with the tests and records and his own findings in hand? The validity of these reviews after the fact is highly questionable.

The quality of care is more than a checklist. It must have something to do with bringing the patient to the point where he can circulate in public life and function as a useful member of society.

There is more to this than another cumbersome bureaucratic burden. There is a basic corruption of the system here. Paid hospital staff, persons whose livelihoods depend on the good will of the hospital administration, call doctors not only to pressure them into doing the kind of things described, but also to alter records of discharge diagnoses in order to obtain as much money as possible. We are asked to rearrange the discharge sheet listing the illnesses treated in such a way to get the most financially out of the patient's admission. The aim is for the hospital to profit from the DRG's.

I might add the doctors are not the ones who profit; it is the hospitals.

In no way do administrative assistants, quality control consultants, and utilization review members contribute to the care of the patient.

In closing, I want to say that I am interested only in being allowed to practice medicine. I should not be penalized because I choose to care for complicated, very sick patients or because I care for people of limited means. Neither should the patient be penalized because he is sick with more than one illness or because he is poor. Relief is needed and the situation is rapidly growing worse. The PRO's are well intentioned but have been asked to do an unrealistic job under unreasonable circumstances. More flexibility must be built into the system.

Thank you.

Chairman Heinz. Thank you very much, Dr. Greenberg.

Dr. Brodsky.

STATEMENT OF DAVID M. BRODSKY, Ph.D., PROFESSOR, DEPARTMENT OF POLITICAL SCIENCE, UNIVERSITY OF TENNESSEE AT CHATTANOOGA

Dr. Brodsky. Senator Heinz, I am the University at Chattanooga Foundation professor of political science at the University of Tennessee at Chattanooga, and I appreciate the opportunity to address you today concerning the effects of the DRG-based reimbursement system on the quality of health care given to older Americans enrolled in the Medicare Program.

The Prospective Payment System and DRG's were intended to accomplish two objectives: To control the rate of growth in Medicare expenditures, and to maintain the high standard of care available to Medicare enrollees. We have already seen evidence to suggest that the Prospective Payment System is an effective weapon in the fight to control Federal Medicare expenditures, and the performance of the system in achieving its cost control objectives is not my concern today. Instead, I want to offer an initial assessment of the Prospective Payment System's performance in maintaining the quality of care available to our Nation's elderly citizens.

Recent testimony before the House Select Committee on Aging, the preliminary results of a General Accounting Office study conducted for this committee, and today's earlier testimony suggests that the evident progress in controlling costs may have come at a high price—a decline in the quality of care available to Medicare patients. Indeed, a recent survey of physicians conducted by the American Medical Association and reported in the New York Times indicates that the Nation's doctors are worried that the Prospective Payment System has either already hurt the quality of care or will hurt it in the near future.

My testimony is based on the results of personal interviews with administrators at each of the hospitals and nursing homes in 10 southeast Tennessee counties as well as from a sample of 75 physicians serving the area's 55,000 elderly residents. The providers interviewed answered a number of questions designed to find out their perceptions of the Prospective Payment System, their evaluations of DRG's and their assessment of the effects of the system on health care costs and on the quality of care given to Medicare patients.

Large majorities in each of the provider groups agreed that DRG's had succeeded in a number of areas including helping to hold down the cost of treating Medicare patients, making hospitals try to operate more efficiently and contributing to reductions in the length of hospital stays.

Despite their willingness to recognize the Prospective Payment System's successes, the respondents strongly criticized what they perceived as flaws in the system's design and implementation. Fifty percent of all respondents described the DRG's as too rigid or as too simplistic. The chart (Figure 1)[1] shows that more than two-thirds of the hospital administrators, nearly one-half of the physicians and a third of the nursing home administrators felt that the DRG categories failed on two counts: Either they failed to adequately take into account complications arising during the course of an illness or they resulted in the inappropriate classification of elderly patients with multiple chronic conditions. As one physician told us, "They are trying to make us do cookbook medicine, but illnesses and patients do not follow a recipe."

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[1] See p. 46.

Forty-nine percent of the administrators and physicians interviewed also believed that DRG's and Prospective Payment have hurt the quality of care to Medicare patients. The data in the chart (Figure 2) [2] indicate that almost one-half of the respondents in each provider category agreed with the statement asserting that DRG's had negatively affected the health care delivered to Medicare recipients. Nursing home administrators frequently mentioned an increase in sicker patients, patients requiring heavier care, care that in many cases they felt that they were not able to provide.

These findings, when viewed in conjunction with other evidence received by this committee, strongly suggest the need for legislation to correct the flaws in the Prospective Payment System and the DRG categories used to determine reimbursement. A Severity of Illness Index may be needed to facilitate the provision of appropriate care while maintaining incentives for cost effective treatment. Such an index would take into account complications and other factors affecting the cost of proper treatment and would no longer provide hospitals with an incentive to deny necessary care.

[The prepared statement of Mr. Brodsky follows:]

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[2] See p. 47.

ASSESSING THE IMPACT OF PROSPECTIVE PAYMENT BASED ON DIAGNOSIS RELATED GROUPS (DRGs)*

TESTIMONY FOR SUBMISSION TO THE RECORD OF THE
SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

26 SEPTEMBER 1985

by

David M. Brodsky, Ph.D.**

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ASSESSING THE IMPACT OF PROSPECTIVE PAYMENT BASED ON DIAGNOSIS RELATED GROUPS (DRGs)

The enactment of Medicare and Medicaid in 1965 marked the federal government's assumption of primary responsibility for protecting the retirement income and health of older persons by helping them meet their medical expenses. Although policy makers never clearly defined the exact parameters of this commitment, it apparently rested on two beliefs: that medical care should be available whenever needed and that costs should not be considered whenever health or life were at stake. The dramatic growth in federal Medicare expenditures (from $7.1 billion in 1970 to $53 billion in 1983) led policy makers in the executive branch and in the Congress to seek a balance between protecting health and controlling costs.

The recently implemented system of prospective payment based on diagnosis related groups (DRGs) represents one element of the federal government's strategy for limiting costs while maintaining the quality of care. Proponents of prospective payment argued that a change from the existing retrospective cost-based reimbursement system would control the growth in federal health care expenditures. More importantly, the advocates of a change asserted that prospective payment would accomplish this objective without negatively affecting the mix and the quality of health care services available to Medicare recipients.

Recent government reports cited in the national press suggest that the prospective payment system has more than met its proponents' expectations. The rate of health care inflation slowed from 6.4 percent in 1983 to 6.1 percent in 1984. The 9.1 percent growth in total health care spending for 1984 represents the smallest increase in two decades. The average length of hospital stays for Medicare recipients decreased from 9.5 days in 1983 to 7.5 days in 1984.

Unfortunately, the news reports also indicate that the demonstrated progress in containing costs has come at a high price -- a decline in the quality of health care ~~made available~~ to

Medicare beneficiaries. The results of a survey sponsored by the American Medical Association reveal that a majority of the responding physicians felt that the prospective payment system already has (or will eventually) negatively affected the quality of care delivered to Medicare patients (New York Times, 1985). Testimony before the House Select Committee on Aging and the preliminary results of a study conducted by the General Accounting Office for the Senate Special Committee on Aging suggest that shorter hospital stays for Medicare patients may also mean these patients are being discharged in poorer health. If these findings accurately reflect the impact of the DRG-based prospective payment system on the quality of care, the Congress and the executive branch will need to take corrective action.

The data presented here represent the results of a first effort to assess the impact of the DRG-based prospective payment system. Physicians, hospital administrators and nursing home administrators were asked to evaluate the prospective payment system DRGs and their impact on the quality of care available to Medicare patients. The findings raise major questions about the design and operation of the DRG classifications used to determined reimbursement and, more importantly, about the effects of prospective payment on the health of Medicare recipients.

METHODOLOGY

The data for this study were collected during late 1984 and early 1985 in ten Southeast Tennessee counties, predominantly rural in character but also containing Chattanooga, a major urban center. Nineteen hospitals and twenty-one nursing homes serve the areas's 54,495 persons age sixty-five and older.

The Congressional Budget Office (1983) reports that 20.5 percent of all noninstitutionalized Medicare enrollees had at least one hospital stay during 1978 and that enrollees averaged six physician visits a year. These figures, when applied to the study area's elderly population, provide a basis for estimating the extent to which Medicare eligible persons utilized hospital and physician services during 1984. The data suggest that Medicare enrollees in the area accounted for more than 11,000 hospital admissions and more than 300,000 physician visits during the last year.

Data Sources

In-depth personal interviews were conducted with the administrators at all the hospitals and nursing homes serving the ten county study area and with a sample of seventy-five area physicians from specialties where they could reasonably be expected to include Medicare beneficiaries among their patients. Table 1 displays pertinent data about the three groups of providers. Over three-fifths of the hospital administrators and an even larger proportion of nursing home administrators represented investor-owned facilities. All but one hospital and two nursing homes were affiliated with either a national or a regional chain.

The vast majority (76 percent) of the physician sample practiced medicine in Chattanooga or its suburbs. One-third of the physicians described themselves as primary care givers. Fifteen percent of the sample said they never accepted assignment for Medicare patients, 53 percent accepted assignment on a case by case basis and 32 percent accepted assignment for all Medicare patients.

Data Analysis

This report presents data drawn from the sample of physicians and from all hospital administrators and nursing home administrators. Respondents from each of the provider groups answered an array of questions designed to assess their perceptions of the prospective payment system and its attendant DRG categories and to obtain their assessments of how the shift to

DRG-based prospective payment has affected the quality of care delivered to older persons. The analysis first compares the responses for each group of providers. Then response patterns within each provider group are examined.

RESULTS

The providers were first asked to identify what they saw as the strengths and weaknesses of the prospective payment system based on DRGs. They were then asked to assess the impact of the system on physicians, hospitals and nursing homes. Finally, the providers were asked to indicate whether they agreed or disagreed with a number of statements describing possible effects of prospective payment and DRGs.

An examination of the data presented in Table 2 reveals that substantial majorities of the respondents in each of the provider groups expressed agreement with a number of statements reflecting the goals set forth by advocates of prospective reimbursement. The respondents agreed that DRGs had helped hold down the cost of treating Medicare patients, had led hospitals to try to reduce costs, had made doctors more aware of the cost of medical care, had led doctors to think twice about admitting Medicare patients to the hospital and had contributed to reductions in the length of hospital stays.

Despite their willingness to acknowledge the prospective payment system's success in controlling costs by making providers more cost conscious, the respondents strongly criticized what they perceived as flaws in the system's design and implementation. When they were asked what problems they saw with the current system of prospective payment based on DRGs, a majority (50 percent) mentioned problems with the DRGs themselves or problems with the effects of DRGs and prospective payment on the quality of care available to Medicare patients. The data displayed in Figure 1 indicate that DRGs concerned a greater proportion of hospital administrators (68 percent) than of physicians (49 percent) or the nursing home administrators (33 percent).

Almost without exception, the criticisms of DRGs described them either as too rigid or as too simplistic. In the former case, the responding providers indicated that the system was not sufficiently responsive to complications which might develop during the course of treating a given disease or condition. As one physician put it, "They're trying to make us do cookbook medicine, but illnesses and patients don't follow a recipe." In the latter case, the respondents characterized DRGs as poorly suited to classifying older patients, especially those with multiple chronic illnesses likely to make more difficult and more costly the treatment of an acute condition.

Although physicians and nursing home administrators proved somewhat less likely to have mentioned problems with DRGs, they too criticized the structure of the categories. Their concerns focused on the rigidity of the DRG categories and their inadequacy to the task of appropriately classifying older patients with complicating conditions.

Assessing the Impact of DRGs on the Quality of Care

When physicians and administrators were directly asked if DRGs had hurt the quality of care provided to Medicare patients, a near majority (49 percent) agreed. The data displayed in Figure 2 indicate that a majority of nursing home administrators (50 percent) and sizeable proportions of hospital administrators (47 percent) and physicians (45 percent) believed the DRG component of the new reimbursement system had diminished the quality of care received by Medicare enrollees.

FINDINGS AND CONCLUSIONS

Based on the results of this study, the following can be stated:

1. Providers of health care in the Southeast Tennessee Development District generally agree that the shift to the DRG system of prospective payment has led to a greater cost-consciousness and cost containment by physicians and hospitals;

2. Though the providers felt the costs of health care had been reduced by the DRG system, they did not feel the categories within this system effectively dealt with the health problems experienced by elderly persons. Specifically, providers felt the categories were too rigid to take into account the complications that often develop during the course of treatment; and,

3. Sizable proportions of providers believe that the DRG system of reimbursement has diminished the quality of health care received by Medicare recipients.

The above findings lead to two conclusions: 1) that the federal government's strategy of prospective payment based on diagnosis related groups (DRGs) has generally succeeded in slowing the rapid rate of growth in costs of Medicare expenditures, and 2) that the prospective payment system has had a negative effect on the quality of health care services delivered to Medicare beneficiaries because the DRG categories used fail to take into account the complicating factors often present in older patients. The data clearly indicate the need for modifications which will allow better classification of patients and their illnesses. A Severity of Illness Index is needed to facilitate the provision of appropriate care while maintaining incentives for cost effective treatment. Such an index would take into account complications and other factors affecting the cost of proper treatment.

TABLE 1: PROVIDER SAMPLE CHARACTERISTICS

	N	%
Physicians		
Primary Care	24	32%
Other	51	68
Urban	57	76%
Rural	18	24
Accepts assignment for some or all patients	64	85%
Does not accept assignment	11	15
Hospital Administrators		
Public or Not for Profit	7	37%
Investor Owned	12	63
Average Annual Daily Census		
less than 50	12	63%
50-100	3	16
over 100	4	21
Medicare Percept of Census		
under 50	11	58%
50 or more	8	42
Urban	9	47%
Rural	10	53
Fiscal Year Budget		
under $10 million	10	53%*
$10 million - $44 million	6	32
$45 million and above	3	16
Nursing Home Administrators[1]		
Public or Not for Profit	5	28%
Investor Owned	13	72
Serve Medicare Patients	7	39%
Do Not Serve Medicare Patients	11	61
Urban	7	39%
Rural	11	61
Fiscal Year Budget		
less than $1 million	6	33%*
$1 million - $2 million	6	33
over $2 million	4	22
Not Available	2	11

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[1] Responses from two nursing home administrators have been deleted due to incomplete data.

*Percentages may not total to 100 percent due to rounding error.

TABLE 2: AGREEMENT WITH STATEMENTS DESCRIBING THE EFFECTS OF DRGs

"Now I'd like to know whether you agree or disagree with the following specific statements some people have made about the impact of DRG's on hospitals, doctors, nursing homes and patients."

	Physicians		Hospital Administrators		Nursing Home Administrators	
	N	%	N	%	N	%
DRG's have helped hold down the cost* of treating Medicare patients	50	69%	17	90%	15	83%
DRG's have led hospitals to try to reduce costs	66	88	19	100	17	95
DRG's have led doctors to think twice about admitting Medicare patients to the hospital	54	72	15	79	15	83
DRG's have made doctors more aware of the costs of medical care	64	85	14	74	10	56
The DRG system has led to a reduction in the length of hospital stays	60	80	17	90	9	50

Figure 1: Percent reporting problems with DRG's.

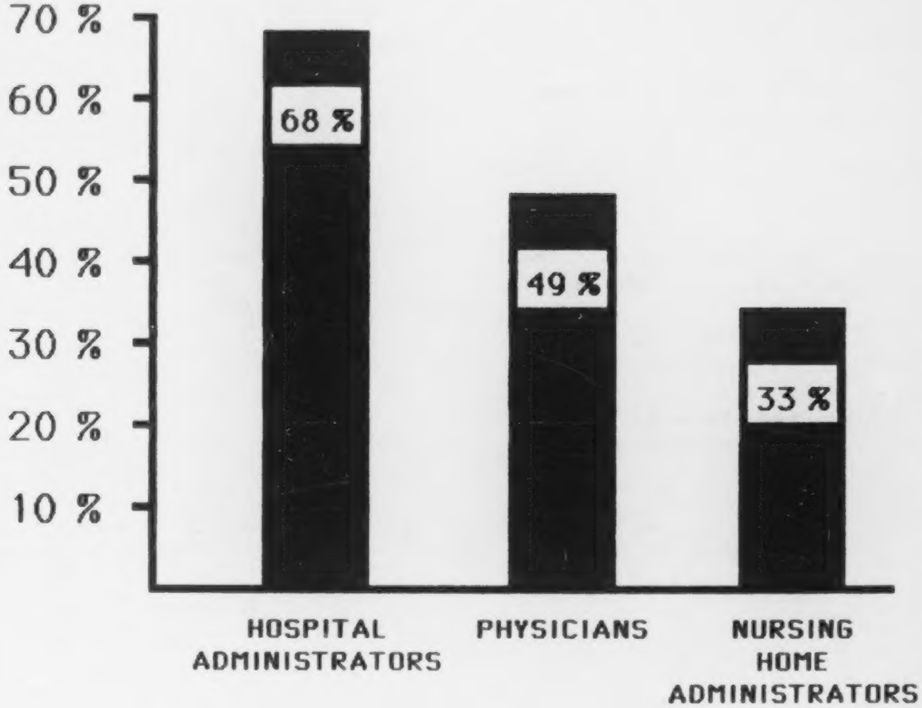
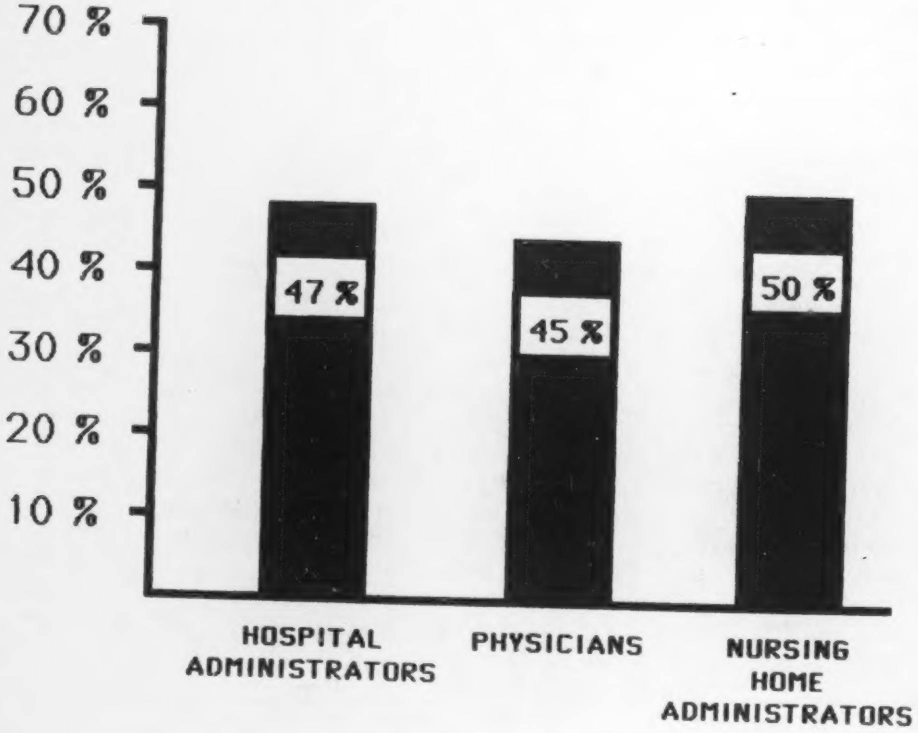


Figure 2: Percent agreeing that DRG's have hurt the quality of care.



Chairman HEINZ. Dr. Brodsky, thank you very much.

I am going to keep my questions relatively brief, because we still have one more panel to go and I want to be sure Senator Warner has the opportunity to answer any questions that he has.

I would like to begin, I guess, with Mr. Jones. You did not testify, Mr. Jones, and you do not have a card in front of you. So you are unidentified at this point. But you are the chief executive officer of a midsized community hospital; is that right?

Mr. JONES. That is correct.

Chairman HEINZ. Indeed, I believe you are the chief executive at the hospital where Dr. Hunter has medical privileges; is that not correct?

Mr. JONES. That is correct.

Chairman HEINZ. Let me ask you: Have you encountered situations where physicians on your staff have failed to admit patients even though the physicians felt that medically the patient belonged in the hospital? And if so, what was the motivation for that behavior?

Mr. JONES. Senator, I am not aware of any such cases per se, but I can certainly see where, because of the tight criteria that physicians have to deal with, that that can certainly occur.

Chairman HEINZ. Would you care to describe the impact of prospective payment on the quality of care?

Mr. JONES. Certainly.

In our institution, the number of Medicare admissions went down from about 2,500 to about 2,000. I cannot tell you exactly what that means, but I think it is obvious that there is some change taking place on the front end with regard to care.

One of the concerns that we had was that physician behavior would be affected by the regulations as they came down. A review organization spoke to our medical staff and said, among other things, that if you have a certain number of admissions denied, you will end up on what amounts to a blacklist. That had an effect on my physicians' behavior. There has been no pressure from our particular institution to modify the physicians' behavior; as a matter of fact, we have been trying to work the other way to reassure them that in our institution we want quality care to continue. I can only speak for our institution.

Chairman HEINZ. You mentioned a blacklist. How would that blacklist be created? Where does the fear of that lie?

Mr. JONES. Well, the statement came from a physician review or from a review organization that came to speak to the medical staff. My guess would be that there have been some very serious blacklisting type of things coming from the Medicare fraud and abuse programs in the past, and no physician wants to be on any kind of a blacklist where he looks bad compared to his peers or in the eyes of the general public. No one wants to be on any kind of a blacklist. That was a word that came from the mouth of the reviewer that came to instruct our physicians.

Chairman HEINZ. Now, in a sense, Dr. Hunter, you, in your testimony, indicated that you had to order treatments for sick patients in order to conform to the admission criteria set forth by the cookbook that, I guess, Dr. Brodsky described.

Two questions: Did you feel that you would be put on some blacklist if you admitted a patient without prescribing these extra treatments?

Dr. **Hunter**. Well, certainly, if I, in my practice, have a certain number of cases that a denial is issued for during a 3-month period, I myself might be put on a 100-percent review. A 100-percent review could then lead to other types of punishment, such as Mr. Jones is talking about, the idea of being held up for ridicule by putting on a list that says this guy is a bad doctor because he admits too many patients to the hospital. It is a fear we all have and one we never thought we would ever have to face.

Chairman **Heinz**. And as a result, you are having to order some extra tests to conform to this recipe that somebody, some nameless, faceless bureaucrat has cooked up for a specific admission.

Dr. **Hunter**. Yes; this little handbook called a physician's DRG handbook was formulated by a small hospital in North Carolina. All our physicians carry this now, because you immediately have to turn to this; we do not go to the bigger textbooks in medicine anymore, because they really do not help us. But the DRG handbook will keep us out of trouble.

Chairman **Heinz**. You went to medical school for 4 years, I assume, and how many years did you do an internship or residency?

Dr. **Hunter**. Internship and 3 years of residency, and I am board certified in internal medicine and a fellow of the American College of Physicians.

Chairman **Heinz**. And so you probably spent what, 8 years training to be a doctor? How many books do you think you had to read and how high would they stand if you kind of piled them up?

Dr. **Hunter**. I suppose to the ceiling, but it does not matter anymore.

Chairman **Heinz**. And they have been replaced by that?

Dr. **Hunter**. Yes.

Chairman **Heinz**. Is that progress?

Dr. **Hunter**. No; that is not progress.

Chairman **Heinz**. Are you——

Senator **Warner**. Mr. Chairman, would you yield for a question at that point?

Chairman **Heinz**. I would be happy to yield to my good friend from Virginia.

Senator **Warner**. I am concerned by a phrase in here where, in your testimony, you are describing the following: "Both she and her family desired admission to our local hospital, but this cannot be unless orders are written for intramuscular injection of pain relievers at least three times daily—medication she may not need that often."

Now, does that open you up to malpractice?

Dr. **Hunter**. I suppose that that probably does.

Senator **Warner**. Well, then, you are between a rock and hard wall, between the "blue book" and the malpractice fraternity.

Dr. **Hunter**. Yes, sir.

Senator **Warner**. Thank you, Mr. Chairman.

Chairman **Heinz**. Thank you, Senator Warner.

Let me ask one other question, Dr. Hunter.

You spoke of patients being denied care because of premature discharge. Could you elaborate on that. And the reason why I ask that is that North Carolina, according to the Health Care Financing Administration, has not reported a single premature discharge through the reporting system that is supposed to be operative.

Are you aware of any premature discharges?

Dr. HUNTER. Well, you will note in my testimony I did not have any examples. We are very fortunate in that we have a good relationship with our administrator, and our administrator has not put any pressure on us such as we heard earlier, to get patients out of the hospital.

He leaves decisions about appropriate discharge entirely to the attending physician. And likewise, the utilization review committee of our hospital does not put pressure on attending physicians, because we trust the judgment of the physicians who are on our staff. We think we have a very competent staff of physicians.

So the premature discharge and the inherent dangers is something that could be feared, but because of the kind of relationship we have with our hospital administrator and our hospital board of trustees, that has not been a problem for us.

Chairman HEINZ. Let me ask Dr. McKenzie, who is also from North Carolina, if he is familiar with any premature discharges.

Dr. MCKENZIE. Well, I mentioned one on the urology case where the admission was denied as unnecessary, and readmission was denied because he had been discharged too soon from the first admission that was denied.

Chairman HEINZ. Are there any others that you are familiar with personally?

Dr. MCKENZIE. No, sir. I am familiar with the pressure to facilitate the movement of patients out of hospitals, and I think that all doctors feel this unconsciously, because there has been a great deal of publicity to the fact that health care has to be rationed, and many hospitals in North Carolina are to be bankrupt——

Chairman HEINZ. I must say I view with some suspicion a reporting system which reports that there are no premature discharges and yet, as you describe, denies reimbursement for an admission because the patient was prematurely discharged previously. It seems to me that something is wrong, and many of them——

Dr. MCKENZIE. Maybe that does not fit the blue book if the first admission was denied.

Chairman HEINZ. Let me also say that—I gather you are not too pleased with the Peer Review Organization System, especially the retrospective review of patient records to determine denials.

But my question is how else are we going to determine and identify those physicians who may be impaired or who, in fact, may be prematurely or inappropriate discharging physicians if we do not have that kind of a system?

Dr. MCKENZIE. I would much rather have it done on a local basis. I think that all doctors who treat Medicare cases can be considered obligated to review these situations, and let them be reviewed there. And if there is a conflict possibly on down the line, it might be reconsidered by an appeal to a far distant organization. But this bit of paying a doctor a high fee—some might not consider $55 an hour for review high, but I do—to anonymously increase the number of denials—and the pressure from Washington is certainly great to increase the number of denials in North Carolina—I think that system——

Chairman HEINZ. Are you suggesting in any respect that we should get physicians who are familiar with treating elderly patents to do more of these reviews?

Dr. MCKENZIE. Yes, sir; I think they certainly should.

Chairman HEINZ. Do them on the local level.

Dr. MCKENZIE. This would not be a great imposition on the doctor, because if all doctors treating such patients were participating, I might not require more than a few weeks a year.

Chairman HEINZ. And they would not need to be compensated for that.

Dr. MCKENZIE. That is right.

Chairman HEINZ. One last question before my time expires.

Dr. Greenberg, you stated that physicians, presumably in the hospital where you practice, are asked to rearrange the discharge sheet to, as you put it, "get the most financially out of the patients' admissions," so hospitals can profit—not doctors, but hospitals.

Could you elaborate on that for us, and could not such tampering and falsification of hospital records lead to prosecution and libel suits, and so on?

Dr. GREENBERG. Well, I will answer the second part first. I do not think it would lead us into any libel suits, but if the original reason for which the patient was admitted was diabetes, and that indeed was the reason the patient may have been admitted, and you put that us No. 1, but then you find that during your workup and treatment that the patient also has cancer of the pancreas with metastasis of the liver and bone, plus then develops endocarditis and heart failure, and finally death from that—the main reason I brought the patient into the hospital was for the diabetes. But weeks later, you may be called by the record room, who has a committee of reviewing physicians, which states that if you put down that the patient has cancer, metastatic, of the liver and the bone, we will get $1,600, and could you rearrange on the front discharge sheet——

Chairman HEINZ. You were being asked to do that?

Dr. GREENBERG. Yes.

Chairman HEINZ. Even though that was not——

Dr. GREENBERG. As long as all the diagnoses appear; but they would like to rearrange it is a numerical way that would give the hospital the best reimbursement.

Chairman HEINZ. How did you feel about that?

Dr. GREENBERG. At first, I fought. But after a while, you get tired of fighting. You only have so many hours a day. And then you say, "Yes," because really, you are not saying anything that is not truthful. You are just rearranging in a numerical way the diagnoses.

Chairman HEINZ. So, what you are being forced to do by the rigidity of this system, a system which does not allow for the severity or complexity of illness is to disregard appropriate judgment and to say things that are untrue. For example, you did not admit a patient because of cancer, you admitted him because of diabetes; and you found cancer later. It seems to me that what you are describing is rigidity in a system which, taken to its ultimate conclusion, leads to a total disregard of really wanting to tell the truth and the whole truth.

Is that a fair summary?

Dr. GREENBERG. That is true. The main reason the patient may have come in was for the diabetes, and secondarily, these other things occurred.

Chairman HEINZ. I am concerned that it also creates a pattern of behavior that begins to invite other kinds of reporting anomalities, abuses, inaccuracies, that cause us to be unable to tell how this system is working.

Senator Warner, my time has expired.

Senator WARNER. Thank you very much, Mr. Chairman.

It seems to me what we are looking at here is that Congress and the executive branch framed a network of laws and regulations which are beginning to suppress the judgment of well-trained men and women in the various stages of the medical profession, that being doctors to nurses. Now we have got to see what we can do to correct that and bring it into balance such that this very precious skill that each of you have through many, many years of training and sacrifice, can be fully utilized to provide quality medical care.

I would pose two questions, and then anyone who desires may address the question. First, in view of the continuing rise in malpractice suits, do you find that—calling on my question of Dr. Hunter—that any of this network of law and regulations requiring you to do things that you otherwise would not do in your professional judgment, will lay a foundation for malpractice charges being brought against you?

And second, it seems to me that the motivation which enables a young man or a woman to enter this profession is to have an unfettered ability to exercise your judgment at the end of the training period.

Is this framework of law and regulation discouraging young men and women from entering the profession of medical care?

Two questions, and anyone who might wish may address it.

Yes, Dr. Greenberg?

Dr. GREENBERG. As far as your second statement is concerned, I do think less capable students are entering medicine. I think the quality of the student who applies to medical school now is different than the quality of the student who applied to medical school 15 or 20 years ago. And I think that some of them sense the problems associated with the control of their lives, the way they practice, the way they think, and their freedom, that has been infringed upon. And I do not think you see the quality of students going to medical at the same level as they have in the past.

Senator WARNER. Dr. McKenzie.

Dr. MCKENZIE. Senator Warner, again, on the first question of malpractice, there is no question in my mind that the whole system does increase the malpractice risk, and the cost to the Government of the malpractice situation, the threat of malpractice suits, is enormous. I do not think there is anything, any single thing that we could do to better extend the medical doctor than to improve the medical malpractice laws, and by that, I have for some time been attempting to get our medical society to get the people of

North Carolina to search for the ideal laws for themselves—not laws ideal for the doctors or for the hospitals, but for the people. I think we could practice good medicine under such laws. But the current situation, as I am sure you are familiar with, is just terrible.

Senator **WARNER**. Well, in succinct response, the DRG system is contributing to the malpractice problem?

Dr. **GREENBERG**. I certainly think so. I do not think there is any way to conclude anything different.

Senator **WARNER**. And that is because certain physicians have to abrogate better judgment and perform certain medical practices on a patient in order to enable that patient to qualify?

Dr. **GREENBERG**. Quite correct, yes, Senator.

Senator **WARNER**. Thank you very much.

Does anyone else wish to respond?

Dr. Brodsky.

Dr. **BRODSKY**. Just a quick response. Many of the physicians that we talked to express the same concern, that they are doing things not because they are medically necessary, but because they are required to do them by DRG categories or by the fear of malpractice, one or the other.

Senator **WARNER**. Well, now, you could not go into a malpractice suit and raise a little blue book as a defense, could you?

Dr. **BRODSKY**. I would think not.

Senator **WARNER**. Yes, Dr. McKenzie.

Dr. **MCKENZIE**. If I may add one comment, a friend of mine was discussing a suit. He is a family practitioner, and he is being sued for a patient who died from a heart attack. He stated in talking to me, "If it were not for those DRG's, I think I probably would have admitted him to the hospital earlier." He did not even know that I was coming here. He was just talking, because he knew of my interest in the malpractice problem.

Senator **WARNER**. I thank you, Mr. Chairman.

Chairman **HEINZ**. Senator Warner, thank you very much for some very good questions. I think your point, Senator Warner, about the blue book, the bible, being no defense against——

Senator **WARNER**. Let us not equate it to a bible.

Chairman **HEINZ**. I know what you are thinking of—but it has become an administrative, bureaucratic bible, unhappily.

Senator **WARNER**. I refer to it as a Popular Mechanics book to fix an engine.

Chairman **HEINZ**. Well, whatever. It is not, as you said, a defense against malpractice. It is a book of regulations that may, in fact, at times be totally inconsistent with the effective and humane practice of medicine.

I just want to note, before I call on him, that Senator Wilson of California has been in and out of this hearing several times today. He is on a number of other committees that are meeting today. And although this is my first chance to recognize him for any statement or questions, he has been here at this hearing on at least one other occasion. I can testify to that, and so do.

Senator Wilson.

STATEMENT BY SENATOR PETE WILSON

Senator **Wilson**. Thank you, Mr. Chairman, and I thank you also for holding the first of what I understand will be three hearings in this area. I think it is critically important that as we seek to wrestle with the monumental problem of cost containment, that we not sacrifice the quality of care required, and I think it is a special quality of care in the case of elderly citizens who, as we have heard this morning in the testimony, often present a multiplicity of impairments not immediately apparent upon admission.

And I commend you not only for taking the initiative, but also for your own legislation that seeks to speed payment to PRO's to remedy one of the problems that has surfaced since that system of review was initiated.

I apologize that other responsibilities have prevented my being here, but I have looked at the testimony, and I do have some questions.

I would like to pursue the line of questioning that Senator Warner has, I think very properly, given emphasis.

Has there yet been any reflection of the concerns that he has articulated this morning and that you have echoed in rising malpractice premiums. In other words, is it a fair statement that the concerns that you have voiced this morning and that are reflected in the results of Dr. Brodsky's survey—have those found their way into higher premiums?

[The prepared statement of Senator Wilson follows:]

Prepared Statement of Senator Pete Wilson

The case we will hear today will both shock us and impress on us the need to assure the delivery of quality medical care in the context of needed efforts to contain costs. The testimony from the professional providers of care illustrates the complexity of the problem.

Our purpose this morning must be to determine whether major overhauls, or only fine-tuning is required to provide that assurance. Mr. Chairman, I commend your own efforts in this regard. I refer to S. 1653 now incorporated into our reconciliation package, your legislation to speed payment to peer review organizations.

I look forward to holding a similar hearing in California, focusing special attention upon health maintenance organizations.

Mr. Chairman, Let me thank you for the opportunity which you have given us to examine one of the crucial issues facing our elderly citizens today, the fear of not getting appropriate medical treatment under the Medicare system.

Overwhelming fiscal pressure to control burgeoning Medicare costs has brought major reforms as a result of efforts by everyone involved in the Medicare system: The administration's implementation of the prospective payment system, the positive efforts by hospitals to maintain their standards while cutting inefficient or costly practices, the serious committment by the private sector employer to make their employees aware of the need for preventive health care.

But it is time to take stock, after nearly three years of prospective payment and less than one year of peer review, to determine whether the system as revised is providing the quality of health care which older Americans require.

Dr. **McKenzie**. Our hospital in North Carolina has been notified to expect a six-fold increase next year in their malpractice insurance. If that happens to me, I simply will not be able to practice.

Senator **Warner**. What would be that fee, if the Senator would yield for a minute, the average fee?

Dr. **McKenzie**. For the hospital, I cannot answer that, Senator Warner. My malpractice insurance runs right at $1,000 a month, and there are doctors in other States who have malpractice insurance that runs almost $1,000 to $2,000 a week, and it is bound to be expensive to go to see such doctors, and they are not taking the money home.

Senator **Wilson**. Now, it may be beyond the ability of anyone in the room to answer this question, because it seems that there are two explanations for that. One would be a pattern of increasing judgments that might have nothing to do with the whole subject that we are focusing upon today. On the other hand, the testimony that we have heard today gives rise at least to the inference that the rigidities of the DRG system are causing a curtailment of adequate patient care and that that may be reflected in these premiums.

Is there solid evidence to indicate the latter?

Dr. **McKenzie**. I cannot give you solid evidence, sir.

Senator **Wilson**. Well, perhaps the best evidence would be statements of the carrier. If they are about to visit a six-fold increase on your hospital, I think at the very least, the hospital is entitled to know why.

Mr. **Jones**. Senator, if I might answer that, North Carolina, in the past 18 months, there have been several multimillion dollar settlements on malpractice cases, which is totally unheard of up until the last year or so. And the insurance companies say, "The settlements are going up, and your rates are going up"—both against hospitals and doctors. Whether or not there is any connection with our discussions today, with that overall pattern, I think it is too early to say.

Senator **Wilson**. Mr. Chairman, I think it would be worthy of the time and effort of our diligent staff to really make a minute examination to determine whether or not the defendants in these cases who have settled, resulting in these fat increases, I mean really unbearable increases, in premiums, have been defendants whose conduct was attributable to the DRG's and to the rigidities of that system. I would hope we would find that that is not the case, but if it is, it underscores what we have heard this morning.

Chairman **Heinz**. Senator Wilson, that is an excellent suggestion, and the staff is directed to find out if those were Medicare-DRG-related incidents.

Senator **Wilson**. Let me in the interest of time, because unhappily, I have been required to be elsewhere—I gather there is a pretty healthy consensus that is reflected in Dr. Brodsky's survey results, that the DRG has proved a very rigid instrument, one that does not take adequate account in particular of the frailties, the special frailties that attach to the elderly.

What is it that this committee can do, what would your recommendation be, for the remedy of that situation? I gather that there is neither an adequate appeal process, and that there is considerable feeling on the part of these panelists that the classification needs to be not just revisited, but revised, and in particular, the severity of illness index. Just exactly how—if you could elaborate, Dr. Brodsky, or anybody else, on that. It seems that what is required is a flexibility that will allow for the expertise that you have all trained for to come to play and not to be prohibited by a rule book that does not accord with the realities of the requirements for medical care on the part of the elderly.

Chairman Heinz. Senator Wilson, let me just ask you to yield for a second, because I had meant to enter into the record earlier, on behalf of Susan Horn, Ph.D., a statement prepared for the Special Committee on Aging, regarding the severity adjustments to the Medicare prospective system. Ms. Horn is a doctor at Johns Hopkins University, and in line with your line of inquiry, it seems to hold great promise in terms of correcting the problem. I just want this to be in the record at the appropriate point.

[The statement of Dr. Horn follows:]

SEVERITY ADJUSTMENTS TO THE MEDICARE PROSPECTIVE PAYMENT SYSTEM

Prepared Statement of Susan D. Horn, Ph.D.

Prospective payment is now in place as one means to control expenditures for hospital care of Medicare (and other) patients. A prospective payment system provides good incentives for hospitals to control the costs of treating patients. However, such a system should be equitable so that hospitals are reimbursed adequately, but not excessively, for the types of patients they treat.

An equitable prospective payment system

With an equitable prospective payment system: There would be no incentive to admit excessive numbers of less severely ill patients, since a hospital would be reimbursed less for such patients.

There would be no incentive to transfer ("dump") or prematurely discharge more severely ill patients that the hospital could actually treat, since it would be reimbursed at an appropriate level for treating such patients.

Reduction of total expenditures for health care would be possible since the government could concentrate on those categories of patients in which resource use could reasonably be reduced. By contrast, when broad, heterogeneous (with respect to resource use) groups of patients are used for prospective payment and one wishes to reduce expenditures, it may be difficult to determine where to start because of the breadth of the categories.

Physicians with atypical practice patterns could be identified and worked with to change their treatment behavior. If heterogeneous groups are used to identify physicians with high levels of resource use, one does not know if the physician's greater resource us is due to differences in his patient mix or to inefficiency.

Characteristics of DRG's

The prospective payment system for Medicare patients now mandated by law uses Diagnosis Related Groups (DRGs) to describe hospital inpatients. The 467 DRGs are medically meaningful in that they attempt to group together patients and procedures that fall together naturally in the practice of medicine. On the other hand, researchers and hospitals have observed that many of the 467 DRGs have a great deal of variability with respect to resource use; in some DRGs, patient charges vary from less than $1,000 to greater than $200,000. This is quantified by large standard deviations of DRG data; standard deviations are often larger than the mean of the charges or length of stay within a DRG.[1, 2]

Overall, DRGs explain only about 30% to 40% of the variability in resource use of hospitalized patients. In a prospective payment system based on DRGs alone, the 60% to 70% of variability in resource use not explained by DRGs causes great uncertainty for hospital administrators, physicians making patient management decisions, and purchasers of health care who need to know what product they are buying.

Some have argued that large variability within a DRG may not be worrisome because analyses of patients' charges within a DRG in the Medpar data file indicate that the distributions are highly peaked, even though they have widely spread tails. If it were true that the more severe and less severe cases in the tails of the distribution were randomly distributed among hospitals, then the great spread of charges within a DRG might not be troublesome. However, studies indicate that some hospitals treat a disproportionately large share of patients either at the higher severity levels or at the lower severity levels.[3, 4, 5] For these hospitals, payment may be either inadequate or more than adequate to cover the costs of treating the respective patients. Hence, a system of prospective payment that contains a large spread of resource consumption within its categories can result in inappropriate levels of reimbursement to certain institutions.

Even if cases at all levels of severity of illness and resource use were randomly distributed among hospitals, the existence of a spread of resource use within a DRG can foster inappropriate incentives in an average cost prospective payment system. As noted in an editorial in the Wall Street Journal (February 6, 1984), a hospital could induce physicians to admit less severely ill patients to that hospital by splitting with the admitting physician the difference between the DRG prospective payment amount and the actual cost of treating that patient. Thus, even if cases were randomly distributed among hospitals, the existence of a spread of severity of illness and resource use within DRGs could permit some fairly obvious inequities to develop. Homogeneity of resource use is, therefore, a very important criterion for an equitable average cost prospective payment system.

Also, when hospitals are not reimbursed sufficiently to take care of the sicker patients, they have an incentive to discharge these sicker patients prematurely. This can lead to poorer quality of care, if the settings to which they are discharged are not used to caring for these sicker patients and/or to more frequent readmissions of such patients, which will cost more money in the long run.

DRGs do not account for severity of illness

Many observers have attributed a major part of the large spread of resource use within DRGs to inadequacies in assessing differences in severity of illness. As a possible means of accounting for severity of illness differences, several researchers have studied the Systemetrics Disease Staging system, used either as case mix system in its own right or as a refinement to DRGs.[6] One advantage of using Disease Staging or DRGs, combined or separately, is that cases can be assigned to categories in both of these case mix systems using standard discharge abstract data; a disadvantage is that the refinement of DRGs with Disease Stages results in many thousands of groups (more than 8,000 groups in one study) while the explanatory power increases less than 10 percent.[6] Thus, even with all these groups, Disease Stages within DRGs are not able to explain much more variability in resource use than DRGs alone, and one is led to question whether Disease Staging provides an adequate definition of severity of illness. Several other systems have been developed that classify patients using only discharge abstract data, (Patient Management Categories, PAS A List, etc), but they, too, explain about the same amount of variability as DRGs. So far, no matter how researchers have tried to use discharge abstract data to form case mix groups, the resulting case mix grouping systems still leave unexplained 60% to 70% of the variability in patient resource use.

Part of this unexplained variability in resource use is due to differences in physician practice patterns. Some physicians perform more tests and keep similar patients in the hospital longer than some of their colleagues. But a large additional part of the unexplained variability in resource use is due to differences in severity of illness that are not captured in the current discharge abstract data base. For this reason, a Severity of Illness Index has been under development and testing at the Johns Hopkins University over the past five years.

The severity of illness index

The Severity of Illness Index assigns to each patient at or after discharge a severity score on a four-level scale, determined from the scores for each of seven individual dimensions chosen to reflect severity of illness. The seven dimensions are:

The stage of the principal diagnosis at admission, including the greatest extent of organ involvement.

Complications due to the principal disease or as a direct result of the therapy or hospitalization.

Pre-existing problems other than the principal diagnosis and its complications, for example, diabetes in a patient admitted with an acute myocardial infarction.

The degree to which the patient requires more than the minimal level of direct care expected for the principal diagnosis; A dependency score above level one indicates that the stage of illness, complications, or pre-existing diseases require extra monitoring or care.

Diagnostic and therapeutic procedures performed outside of the operating room: The highest level of procedure, such as those required for life support, rather than the total number of procedures performed, determines the score for this dimension; the need for such a procedure also should be reflected in one or more of the first three dimensions (stage, complications, and/or pre-existing problems).

Patient's response to hospital treatment for the principal diagnosis, complication, and interactions: this relates to treatments for acute illness or acute manifestations of a chronic illness that one expects to manage during a hospital stay; it does not relate to improvement in underlying chronic conditions for which there is no expectation of cure or significant progress during the hospitalization.

The extent to which a patient shows residual evidence of the acute injury or illness at the time of discharge.

To determine the Severity of Illness score for an individual patient, a rater (usually a hospital medical records coder or utilization review nurse) scores each of the seven dimensions at one of four levels of increasing severity by examining data in the patient's medical record for that hospitalization following discharge. To the greatest extent possible, objective, disease specific criteria are used to define each of the four levels within each of the seven dimensions. Whenever a dimension is scored above a level one, raters are taught to record substantiating criteria such as signs or symptoms, lab values, etc., as notes on the Severity of Illness rating form. The rater assigns an overall Severity score to each patient on a four-point scale by examining the pattern of scores for the seven dimensions.[7] Timing studies have shown that it takes, on average, from minus two minutes to plus three minutes per case to rate Severity of Illness along with discharge abstract coding or discharge utilization review reporting, so the additional task of collecting Severity of Illness data does not add greatly to the current cost of either utilization review or discharge abstracting activities. Reliability studies show an average of 93.5% agreement (6.5% disagreement) when cases are blindly rerated.[7] This compares very favorably with the disagreement rates for principal diagnosis coding found in other studies, which range from 25% to 36.6%[8,9], resulting in disagreement rates for DRG classification averaging 18% in one study.[9]

The quantitative evaluation of illness severity presents a complex and challenging problem. Any approach to solving this problem necessarily entails compromises. For example, in order to avoid the influence of practice patterns and examine only illness related factors, it would be desirable to employ only data that would not be affected by actions takent by patient care personnel. On the other hand, exclusion of such elements, particularly data related to complications and the patient's response to treatment, would ignore factors critical to the determination of the patient's total burden of illness.

Most systems of patient classification, even those currently employed as a basis for prospective payment, accept this compromise to some degree to avoid loss of important information. For example, the DRG classification system includes procedures such as cardiac catheterization, operations that are chosen by the patient's physician, as well as complications and comorbidities that can be influenced by the care given such as contraction of a urinary tract infection. This approach recognizes that to ignore such elements would preclude adequate characterization of the patient's illness. A similar approach was used in developing the Severity of Illness Index, but the influence of hospital-related factors was minimized.

Results when severity is controlled for

To date, Severity data have been collected at more than 60 hospitals. Analyses of these data have shown that DRGs subdivided by the four-level Severity of Illness Index explain more than 60% of the variability in patient resource use, while DRGs alone explain less than half of that.[5,10] Also, in simulated studies of prospective payment based on Severity-adjusted DRGs compared to DRGs alone, the algebraic sum of the deviations between actual costs and DRG predicted payments were always further from zero (that is, there were greater overpayments or underpayments) than the algebraic sum of the deviations between actual costs and Severity-adjusted DRG payments.[9] Thus, a hospital has a greater risk that its total prospective payments will differ from actual costs under an unadjusted DRG system than under a Severity-adjusted DRG system. The differences in deviations between actual and predicted patient payments based on DRGs compared to Severity-adjusted DRGs was up to 35% of a hospital's total operating costs, so making (or not making) a severity adjustment to DRG payments can have substantial financial implications for a hospital.[11]

HCFA apparently hoped that although DRGs did not predict individual patient resource use well, the variations would all cancel out at the hospital level. This is not the case in many hospitals. In the future, to achieve equitable prospective payment, a valid and reliable adjustment for severity of illness will be necessary.

Uses of severity information

An appropriate adjustment for severity of illness is essential for any purchaser of health care who needs an accurate definition of the hospital "product" he is buying. Sometimes, institutions that appear to have high costs when DRGs alone are used as the basis of comparison, no longer seem to be high cost institutions when Severity-adjusted DRGs are used as the basis of comparison. The reason they appear to be high cost using DRGs alone is that they are treating proportionately more severely ill patients.

With an appropriate severity adjustment to DRGs, not only would purchasers have more accurate information for their decisions, but hospitals would have more accurate information to assess themselves, and *all* hospitals would have an incentive to become more efficient. At present, when hospitals that admit typically low severity patients are paid the DRG average, they may have little incentive to become more efficient because their payments may be much higher than their operating costs.

Severity of Illness information can be collected at admission, concurrently during hospitalization, and at discharge measuring the maximum Severity throughout the hospitalization. In this way, changes in Severity can be used to flag possible quality of care problems. Severity criteria can also be assessed to determine the patient's signs and symptoms on the day of discharge to predict the resources needed for post-hospital care, such as home health or nursing home care.

Computerized severity index

In order to facilitate widespread use of the Severity of Illness Index, the Johns Hopkins researchers have developed an expanded ICD-9-CM code book that incorporates Severity of Illness criteria. This new code book is based on a 6-digit system: the first 5 digits are the same as the disease condition labels in the current ICD-9-CM code book; the 6th digit (1 to 4) tells how severe the disease us using objective signs and symptoms, lab values, radiology findings, etc.

The new 6-digit code book will be used to create an expanded discharge abstract data set consisting of principal and secondary diagnoses labelled in 6-digit codes, a rate of response to therapy variable (level 1 to 4, as in the 6th dimension of the Severity of Illness Index), and the usual discharge abstract elements of procedures, age, sex, and discharge status. A computer algorithm will be applied to his expanded discharge abstract data set to produce the overall Computerized Severity Index (CSI). Validity studies have shown that the CSI agrees with the manual Severity of Illness Index about 95% of the time; the remaining 5% of the time, the CSI appears to be an even better predictor of resource use. This new system will be available in early 1986, so all hospitals, including psychiatric institutions, will be able to score severity criteria as part of their discharge abstract coding.

The CSI is based on the quantification of a patient's *total* burden of illness expressed as a combination of:

The problem: the problem or principal diagnosis that brought the patient into the hospital, with the 6th digit reflecting its severity;

The environment: the complications and/or comorbidities the patient experiences while in the hospital, described as the 6th digits of each of the secondary diagnoses;

The idiosyncratic element: the patient's bodily response to the hospitalization or rate of response to therapy.

In the future, DRGs are likely to be adjusted in some way for severity of illness. If this is done correctly, other surrogates for severity, such as teaching status, urban or rural status, proportion of indigent patients, and tertiary referral center designation may not be needed. Then, hospital costs will more accurately reflect necessary hospital use, a situation that will benefit patients, hospitals, and payers, public and private alike.

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Chairman HEINZ. Thank you Senator Wilson. Please proceed, Dr. Brodsky.

Dr. BRODSKY. Well, since my testimony raised the question of the severity-of-illness index, I will just make a few comments.

One, much of the work that has been done is Dr. Horn's work with her associates at Johns Hopkins. And basically, what a severity-of-illness index will do is to look at such things as the stage of the principal diagnosis at admission, look at the presence of complicating factors at admission, the presence of complications which will develop during the course of treatment, and also the condition of the patient upon discharge—how fully recovered they are and the like.

I think all of these things, if you take these into account, will allow more flexibility and not necessarily at greater cost, because I think what we may find happening is that right now, the DRG system is paying the same reimbursement for a patient in a category who is not seriously ill with complicating factors as they are for a patient who is seriously ill. So the hospital makes more money on a not-chronically-ill person, less money on somebody else. So I think the severity-of-illness index will take those sorts of things into account.

Dr. HUNTER. Severity of illness is something that is more or less built into the intellect of a practicing physician. And I think the practicing physician will tell you that he can look at the patient, the patient he has known, and he can tell you the severity of illness. Now, my problem is I am also told I have got to document that. And sometimes, I have labored over a one-paragraph note in a patient's chart, trying to put into adequate words the appearance of that patient, because I know that if I do not put in an adequate description of the appearance of that patient, I am going to be in serious trouble when the reviewer comes through. And any kind of system that would allow us a mechanism of applying a severity-of-illness index would obviously be a great deal of help, because we all labor over this problem of how to describe just how sick a patient is.

Senator WARNER. Before we dismiss this panel, I wonder if there is any thought that we should revisit the question of fees to physicians, by virtue of the ability of the individual to pay. In other words, as I understand it, a millionaire pays the same fee as does a pauper under this system. Obviously, someone carefully thought through the problems before the system was established, but now, after some experience, should that be revisited?

Dr. HUNTER. My only concern today would be if you will just do something about the things that we have talked about about the current DRG system; I think that that will so relieve my mind that I will not worry about the other for a considerable period of time.

Dr. McKenzie. Senator Warner, if I may answer somewhat on that question, I am not so concerned with collecting more from the patient who is wealthy, although I am not sure that they are going to always have Medicare available to them; but I have recently learned that if a truly poor patient comes into my office on Medicare, and I do not attempt to collect the 20 percent that the Government does not pay, I can be charged with fraud, my office closed, and I can be put in jail.

Now, I see many of these patients that come in, and they are on Medicare, and I tell my secretary to just drop the 20 percent—and I hope there is no one taking names here, because I will be visited soon. But this seems to me a terrible threat, that I cannot forgive the 20 percent.

Senator Warner. I share that view.

Dr. McKenzie. I think there are two other things that might help in a minor way. I think it might help if hospitals could have a few beds that could swing and that could be considered as nursing home beds at a time when there is an acute shortage of nursing home beds. We have patients that stay in our hospital for weeks, waiting to get in a nursing home. And if some of the hospital beds could be designated nursing home beds, then I think there would not be that pressure to push them out of the hospital. It is my understanding also that hospitals cannot accept cash, and they cannot accept additional insurance if they are treating a Medicare patient. The earlier testimony on the previous panel alluded to all of the funds that were available, but it is my understanding that hospitals cannot accept those funds. And this might reduce the pressure on the hospitals and the doctors.

Chairman Heinz. I just want to ask a followup to your question of Dr. McKenzie. One possible alternative to the designation of nursing home beds in the hospital would be to expand the existing law, which provides for administratively necessary payments for hospitals where an extended stay is necessary by reason of a lack of nursing home beds. Is that an alternative?

Dr. McKenzie. Yes; I think that would accomplish the same thing.

Chairman Heinz. Thank you.

If there are no further questions, or answers, or suggested answers—Mr. McKenzie?

Dr. McKenzie. Well, I would like to conclude that I think that the system must work, but I do not speak of the system of Medicare and PRO's and DRG's. I mean the system by which the people have developed—the doctors and the hospitals in prior generations have developed the best health care system that the world has ever known.

Chairman Heinz. Let me just ask one more question for a "yes" or "no" answer from all of you, and then we will let you go back to practice medicine as best as HCFA will allow.

Senator Warner. Particularly down in North Carolina, with a hurricane coming. We have four of them here.

Chairman Heinz. Yes. You had better get back there if you can.

As best HCFA will allow, and that is this: DRG's—do you believe that we can, by the variety of suggestions you or others have made—can we improve that system sufficiently so that we can have a reasonable assurance that the quality of care under Medicare will be preserved?

Mr. Jones—yes or no?

Mr. JONES. Certainly, in the short run, I agree. My long-run concern is that as the funds become tighter, then quality has got to give at some point. We are still talking about rationing care, and that is the long-term concern. But in the short run, definitely, yes.

Chairman HEINZ. Yes or no?

Dr. HUNTER. Yes.

Dr. McKENZIE. Yes.

Ms. JONES. Yes.

Chairman HEINZ. What is that? You have come a long way, now. Make sure that people hear your verdict, loud and clear.

Ms. JONES. Yes, sir.

Dr. GREENBERG. No.

Dr. BRODSKY. Yes, in the short run.

Chairman HEINZ. So, we have five "yes," two of them qualified as to the short run, and one "no."

Dr. McKENZIE. May I say that was a small "y" "yes".

Chairman HEINZ. Ms. Jones and gentlemen, thank you very much. You have been extremely helpful to us. We thank you for having come a very long way, and we wish you a bon voyage, especially for the North Carolinians.

Chairman HEINZ. I would like to welcome our next panel. We are very fortunate to have here today experts on how Medicare's Quality Assurance Program is working, or maybe not working. I very much appreciate the willingness of the representatives of the peer review organizations to take the time and trouble to come here today and tell us directly what we need to know—namely, how to best protect Medicare beneficiaries and ensure that we do not drop the word "care" out of "Medicare".

Dr. Thomas Dehn is the president of the American Peer Review Association and a representative of the Wisconsin PRO, I understand, will present prepared testimony.

In addition, we are very pleased to have with us to answer our questions today, Dr. Kenneth Platt, medical director of the Colorado Foundation for Medical Case, accompanied by Arja Adair, executive director; Mr. John W. Miller, chief executive officer of the Alabama Quality Assurance Foundation, accompanied by the medical director, Dr. Robert Sherrill, Jr.; and from Rhode Island and the Maine PRO is Dr. Frederick Crisafulli, medical director, and Edward J. Lynch, executive director. We thank you for being here, and we welcome you all.

Chairman HEINZ. Dr. Dehn, would you please proceed with your prepared testimony, and then it will be my intention to ask a variety of questions from your expert associates.

STATEMENT OF DR. THOMAS G. DEHN, MILWAUKEE, WI, PRESIDENT, AMERICAN MEDICAL PEER REVIEW ASSOCIATION

Dr. DEHN. I appreciate this opportunity, and I think you will find that the resources that you have here at the table will be able to get into some of the technical issues that you have heard earlier today.

As mentioned, my name is Tom Dehn. I am a physician in the full-time practice of medicine in Milwaukee, WI, and the president of the Wisconsin PRO, and the president of the American Medical Peer Review Association, which is the national organization of physician-based review organizations, comprising virtually all of the PRO's in the country.

I have submitted written testimony, which you and your staff will have the opportunity to review, and I would ask that that be entered into the written record at this time, Senator.

Chairman HEINZ. Without objection, your entire testimony will be part of the record in its entirety.

Dr. DEHN. Thank you, sir. That testimony responds to the six questions that you posed upon your invitation of our group, and I believe, after listening to the earlier testimony, that it addresses almost all of the issues raised by today's witnesses.

I will not read from that testimony, because I fear it will cause great somnolence to come over this room, so I will try to paraphrase some of my thoughts today.

I would hope that you and the members of your committee can assist us in the development of an effective program for monitoring and assuring quality of care in the Medicare Program.

I think basically, the question is really who will be the beneficiary advocate in this $75 billion program. I have heard physicians earlier today say that they are having trouble adequately documenting care, or "We do not like to call in."

We submit, when somebody buys 75 billion dollars' worth of a product from the medical profession, we must provide accountability, and it ought to be reasonable accountability, and I believe that the PRO, given the right tools, can provide that accountability on behalf of organized medicine.

We know that you, Senators, are advocates for quality health care, and we know that we are. Unfortunately, in many cases, your colleagues do not support your efforts, and unfortunately, we are hamstrung by what we consider to be a restrictive, underfunded, relatively inflexible and frankly, too narrowly focused program of health care review

Chairman HEINZ. I gather you are referring to second opinion when you say "some of my efforts".

Dr. DEHN. Yes, sir. It happens to be my personal opinion, that focused second opinion programs are effective quality assurance tools.

Chairman HEINZ. But you believe that second opinion legislation is good?

Dr. DEHN. I think that focused use of second opinion, Senator, is very useful. And incidentally, I would welcome—these are hardly prepared comments——

Chairman HEINZ. Well, let us not get into that one today.

Dr. DEHN. Call me again at another time.

Chairman HEINZ. I do thank you, Dr. Dehn. Senator Durenberger and I just have an honest difference of focus on that.

Dr. DEHN. I have heard rumors about that.

The question before us Senator is really not whether the health care system is changing, but what about patient quality, and are Medicare beneficiaries really to suffer from the economic incentives in the system that reward efficiency; are they to be captives, frankly, of the health care policy that is determined by these insurmountable Federal deficits.

We believe that an effective PRO can minimize the damage, hopefully, eliminate the damage, that may be caused by the incentives I have mentioned.

My first concern is the underfunding of the program. Currently, we are encountering what we colloquially refer to as "scope of work creep". The PRO program is currently administered and funded on a fixed-price-contract basis. For those of you who have purchasers in your constituency that have military contracts, you know about fixed-price contracts. The problem is that the fixed-price contracts that the PRO's are operating under have had "creep" in terms of increased administrative requirements, increased workload requirements, but without concomitant increases in reimbursement. We are anxious to get on with the job, but we seem to be doomed to failure by virtue of underfunding. And if we embark upon the kind of broad-based review program that we will suggest to you today, you can expect that the amount of money that will be required to do the job will be substantially greater than that which HCFA has committed to the program now.

Regarding the inflexibility of the program, and in fairness to HCFA—the initial intent, of the PRO program was primarily to monitor compliance with the prospective payment system and effect utilization review. We believe we have done that. We have done that, as you have heard earlier, to a degree where we are beginning to see concerns raised about the quality of that care. Some 200,000 less admissions last year to the hospital certainly raises the question that the fiscal incentives at least have the potential of compromising quality of care.

We believe that the evolution of the PRO now that we have established baseline ability to monitor compliance with the prospective payment system should shift its primary focus to a review of quality.

Now, I introduced this discussion under the topic of "inflexibility", and let me give you an example. I am holding a letter that I, as president of the Wisconsin PRO, had to send out to our membership. And I will quote the first paragraph.

> Presiding over an organization empowered to interpret and enforce Federal guidelines relating to something as complex as health care cost and quality is strangely reminiscent of a Fellini movie. The plot is nearly impossible to understand, though you are certain there is one; the message is frequently unclear, and of course, the actors keep changing.

I sent this letter out relative to one of our latest requirements, and that is to review readmissions. Now, on the face of it, the review of readmissions seems reasonable. Certainly, it would seem reasonable with regard to abuse of the system in terms of churning patients for DRG maximum benefit.

The actual fact is that across the country, PRO's have not seen gaming of the system by readmissions. So it does not seem to have an important impact with regard to utilization. "Churning" has not been our experience, and we have the data to show that.

It's usefulness as a quality monitor—and that is really what we are getting at today, is also somewhat suspect because if a patient has to be readmitted to a hospital because of a compromise of quality on the first admission, we are too late.

In the written proposal that I have asked you to enter into the record, the PRO asks for the ability to perform discharge screening. If we are mutually concerned about premature discharges, then let us look it the patients before they are discharged, rather than wait 3 or 4 days, 10 days, 16 days, 4 weeks, for a significant complication to occur so that we can retrospectively say, you know, maybe that patient was discharged too soon.

The solution is frankly not a solution and I try to explain that to participating physicians in this letter. We now must review and penalize hospitals for all readmissions. The problem is that with Medicare beneficiaries, it is not unusual for a patient to be admitted to the hospital for an illness as serious as cancer of the colon. The diagnosis is made and surgery is suggested. These are elderly patients who might want to think about a serious and extensive operation. The operation, perhaps, for cancer of the colon might be to perform a colostomy. It's not unusual for the patient to say, "Doctor, I want to go home and think about this. I want to put my things in order. I want to talk to my relatives."

A compassionate physician, a compassionate PRO, has up until the most recent directive said, "Do that. Think it over, and come on back in." Most physicians know that that patient will go home, and soon return, in this case for a colostomy.

The problem now is we are being asked to administer a program that says, "You really cannot discharge that patient and let them consider their options. You must use surgical furlough days"—Lord only knows what those are—"or pass days." Essentially, the patient is never discharged from the hospital under a system like that.

It is cumbersome, and it is inflexible. I am asking, on behalf of the PRO's, for the opportunity to institute some innovative flexibile approaches to medical review, such as a simple review of discharges before they occur—not only after an untoward event occurs.

Senator, you heard about a blue book referred to earlier. It is not the PRO's blue book that one would have you believe. The blue book and similar blue book are hospital publications and include some generally accepted guidelines for patient admissions to the hospital and patient discharges from the hospital.

I would like to remind the physicians who are critical of blue book, that the guidelines contained therein were developed by the American Medical Association under funding from the Federal Government, along with the PSRO's, and have reviewed by each local PRO organizations. They are guidelines.

Any physician who, against his medical judgment, refrains from admitting a patient to the hospital because of anything written or a guideline is approaching malpractice. Physicians ought to understand that that their hospital has every opportunity to appeal denial decision. They are not necessarily binding.

Chairman HEINZ. What do you say to the physician, though, and we had one here a moment ago, who says, "Well, that is well and good, but I get 100 percent review before I have had a chance to pursue my appeal"?

Dr. DEHN. Well, I appreciate that question, Senator. In the first place, there is nothing punitive about 100 percent review. I would have to defer my answer to one of our medical directors—I am not certain that he is put on 100 percent review until it is finally adjudicated—is that correct, Doctor?

Dr. CRISAFULLI. It depends upon what the PRO decides to do, the pattern that is established. Now, the 2.5 percent denial rate may mean that that particular physician has 100 percent of his cases reviewed, or 100 percent of the subset relevant to the kinds of denials he had before. But it is not absolutely mandatory.

Chairman HEINZ. What you are saying is it is somewhat confusing. You may or may not get 100 percent review, depending on how someone else looks at it, as a subset or as——

Dr. CRISAFULLI. No; It depends upon how the PRO sees what the problem is.

Chairman HEINZ. I understand, I understand. And since there is room for judgment—which may be good—it still is confusing, because no one knows how it is going to come out. Flexibility also invites some uncertainty, a human law of nature.

Dr. DEHN. I appreciate that comment.

Chairman HEINZ. Well, I did not mean to interrupt you.

Dr. DEHN. Well, I generally speaking, Senator, a physician who practices according to the guidelines of the PRO program but against his medical judgment is practicing medicine that should be reconciled with his peers. And a physician that discharges a patient because prematurely the hospital wants him to is not practicing according to his best judgment. And I do not see that it is a problem with the Health Care Financing Administration, or the Senate, or the PRO program; that is a problem between the physician and his hospital.

Now, interestingly, Dr. Kellawan mentioned earlier that in his best judgment he did not feel that his patient should be discharged. Why did he discharge his patients? Any time that a physician disagrees with a hospital's suggestion that he discharge, he has—and we welcome—the right of appeal to the local PRO. We will stand with the physician to adjudicate that dispute and in the meantime keep the patient in the hospital.

We are here to try to intervene in behalf of the beneficiary if the physicians use us. But if the physician——

Chairman HEINZ. One clarifying question.

Dr. DEHN. Yes.

Chairman HEINZ. It is appealed. The patient is in the hospital. If the patient loses, or the doctor loses the appeal, who pays for the days in the hospital at $500 a day?

My understanding is, the patient and the family.

Dr. DEHN. No.

Chairman HEINZ. If they lose.

Dr. DEHN. No. Interestingly—and I think it bears some discussion, at least briefly—under a DRG system, there is a fixed price. We buy a product. For instance we buy an uncomplicated gall bladder surgery, or a complicated gall bladder surgery, as a unit of care. The discussion today however, has focused on days of care, which are almost irrelevant to the DRG system. If a hospital tells a patient that they have to leave because their DRG days of care are used up, they either do not understand the system, the beneficiary does not understand it, or the hospital is abusing the system. The DRG system is based on averages. Now, if the hospital, by virtue of their computer tracking of the charges that are incurred, decides that that patient should leave, and puts pressure on the physician to discharge the patient, the patient does not have to pick up the extra charge—let me back up—if the physician decides not to discharge the patient, and the patient stays in longer, the patient is not responsible for the additional charge. The biggest problem is that the hospital industry will have to chew into some of the 8-percent profits that they have claims to have made over the last few years on DRG's.

Let me add one of the most important points that I have not yet mentioned and one I am sure you will agree relates to the very point brought up by Mrs. Mahla earlier. The problem of the narrow focus of the PRO program. In my opinion the greatest problem in the PRO program right now, is the fact that it is only a snapshot in the terms of the whole health care continuum.

We do not know whether there are premature discharges in PPS because we do not have the opportunity to review the care after discharge nor do we have the opportunity to review ambulatory care that goes beforehand——

Chairman HEINZ. That is a central point which needs to be emphasized on the record.

Dr. DEHN. I appreciate that.

Chairman HEINZ. Here you are, and it is generally supposed by most members of Congress and by some people downtown that PRO's are supposed to ride herd on quality. And what you are saying is you do not have the information to tell whether people are being prematurely discharged.

Dr. DEHN. I appreciate you underscoring this issue. It is of central importance to the program.

Chairman HEINZ. What I hope is that someone in the administration, which continues to send witnesses up to Capitol Hill saying that there are no problems here, that we have all the information that we need; we will look at what you and your colleagues are saying on this critical issue. And I think it is worth putting into the record at this point a report, prepared by the American Medical Peer Review Association's Task Force on PRO Implementation, dated September 1985, "PROs: The Future Agenda".

[The report referred to follows:]

[The oral testimony resumes on p. 86]

PROs: The Future Agenda

A Report of:

The American Medical Peer Review Association's
Task Force on PRO Implementation

September, 1985

PROs: The Future Agenda

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I. INTRODUCTION

The Peer Review Organization (PRO) program was enacted in 1982 as a bold new effort to revitalize physician peer review in the public and private sectors. The advent of Medicare prospective payment (PPS) and the accelerated growth of Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs) underscores the importance of PROs in safeguarding the quality of patient care under these new payment arrangements.

Today, physician practice patterns, medical technology, and the structure and management of provider organizations are changing at a rapid pace. Concern for quality has risen sharply as the economic incentives of prospective payment are more clearly understood. Congressional and press attention to individual cases of compromised patient care has heightened public awareness.

All the while, insurmountable federal deficits continue to drive health policy decisions. Congress and the Administration seek new opportunities to reduce the Medicare and Medicaid budgets. Evidence of wide variations in practice patterns highlights significant differences of opinion within the medical profession concerning the appropriateness of treatment. Health outcomes must be measured, tracked, and analyzed to help answer the question - which range of practice styles is the most effective? Research is a top priority and forgotten in the present budget debates. Policy makers suggest that if conservative practice styles are proven by research and peer review to be most appropriate, and embraced by the medical profession, health care expenditures could be reduced with positive impacts on quality.

The recent shift of services and technology to the ambulatory setting makes clear the need to assure the quality and medical necessity of health services rendered throughout the continuum of patient care. More sophisticated and integrated inpatient and outpatient data bases must be created to monitor and evaluate utilization and to measure health status before, during and after clinical intervention.

It is in this environment that the purpose, design, and management of the existing PRO program must be debated. The goal is to establish an administratively rational and effective physician peer review program, tailored to the contours of the medical marketplace.

It was with this goal in mind that the American Medical Peer Review Association (AMPRA) - the national association of PROs and other physician directed review organizations - convened a Task Force of its members to develop the enclosed report, PROs: The Future Agenda. While this report is confined to AMPRA's thoughts and recommendations on the Medicare review system, we believe more firmly than ever that physician peer review must be at the forefront of both public and private efforts to assure quality of patient care. AMPRA's hope is that this report will set the framework for discussions with Congressional, Administration, beneficiary and provider leaders as we seek together to chart the future PRO agenda.

I wish to thank the members of AMPRA's Task Force for their time, effort, and creative vision of physician peer review now and in the future. Thanks also to the AMPRA staff for integrating task force deliberations into a final report.

Thomas Dehn, M.D.
Chairman, AMPRA Task Force on
PRO Implementation

II. EXECUTIVE SUMMARY

The American Medical Peer Review Association (AMPRA) believes that the promise of PROs can be realized with program modifications. There are five major areas of reform that must be considered in preparing for the second round of PRO contracts: making more comprehensive and introducing more sophisticated approaches to quality assurance; supporting PRO initiated efforts to document, analyze and implement strategies to modify practice variations; permitting greater flexibility in program and contract administration as intended by the PRO statute; expanding PRO review beyond the inpatient setting; establishing a formal evaluation plan.

Specifically, AMPRA recommends:

1. The application of generic quality and discharge screens to assist PROs in the identification of quality problems under the Medicare prospective payment system. It is recognized that generic screens represent a start in the evolution towards a more systematic approach to quality assurance and must be augmented in the years ahead with the application of severity of illness measures and the monitoring of patient care outcomes over time. Nevertheless, it is a far preferable method of review than the difficult to validate quality objectives now a requirement of the PRO program.

2. The expansion of PRO preadmission certification programs to include review of 100% of all elective admissions. PROs would be permitted flexibility to focus their preadmission review efforts where experience and data can demonstrate that this approach would yield more favorable results. To involve Medicare beneficiaries in treatment decisions, AMPRA recommends PRO discretion in referring difficult cases for second opinions.

3. The support for PRO initiated small area analysis research. The study of admission rate variation by hospital market area can help influence physician behavior through data feedback and assist PROs in refining admission objectives to focus "in" and focus "out" review interventions.

4. The modification of prescriptive rules governing the medical review process that stifles PRO innovation, burdens providers, and too often concentrates PRO energies on activities that do not yield the best results. Consolidation of existing PPS review activities into a single retrospective review sample accompanied by greater PRO discretion to intensify/eliminate review when problems or no problems are identified would enhance program cost effectiveness.

5. Flexibility and fairness in contract administration. Contract payment schedules must be designed in recognition of the limited financial resources of physician based review organizations. Further, while AMPRA does not dispute the need for program modifications, new instructions under fixed price contracts must be accompanied by appropriate change orders and the opportunity for PROs to negotiate additional remuneration for additional work.

6. The introduction of PRO review activities in the ambulatory care setting. Congressional and public sentiment is growing steadily that quality of patient care can not be assured until the full continuum of health care services are brought under scrutiny. This movement towards medical review in the ambulatory care setting must be carefully and patiently planned with emphasis on the development of comprehensive and consistent patient encounter data systems. Congress must make explicit in law funding provisions for the expansion of PRO activities.

7. The establishment of a formal and broad reaching evaluation plan. In principle, AMPRA believes that the evaluation of PRO performance should be based on the impact and outcome of review rather than the process of review. AMPRA believes that this principle was articulated in the PRO statute.

III. PRO PROGRAM ISSUES AND RECOMMENDATIONS

A. MEDICAL REVIEW POLICY

Quality Review - AMPRA believes that the objective of an effective quality assurance program under PPS should be to identify and correct quality compromises that result from incentives which may lead to undertreatment. In addition, instances of clinical mismanagement are a concern in any reimbursement system and should be the focus of appropriate quality review interventions. Finally, maintenance of good quality that can be demonstrated by a PRO is a final goal of quality review.

The present quality assurance system required under PRO contracts is limited, restrictive and lacks the innovation needed at a time when the incentives of PPS raise the potential for compromised care. The imposition of quality objectives presupposes baseline data that can validate the existence of quality problems. Given the advent of PPS, no such data is available across a wide spectrum of inpatient care to the elderly. Only now are quality care concerns surfacing as the PPS system is implemented and gains momentum over time. Furthermore, review of readmissions within seven days, transfer review and the retrospective nature of present review activities does not represent a satisfactory commitment to quality assurance.

AMPRA continues to believe that a broad survey of patient care is needed at the outset of PPS to build a baseline of quality concerns. An effective program must, therefore, be flexible and based on the ability to recognize and correct a broad range of variations from acceptable quality patterns. This approach will require a combination of screening and individual record review.

Recommendations:

1. AMPRA recommends the application of quality and discharge screens for every case reviewed retrospectively by PROs. Criteria for screening should be generic, that is, applicable to a broad range of medical services and not diagnosis specific. Criteria should be appropriate nationally for comparative purposes but the system should be flexible enough to permit regional and local variation. Examples of national criteria include, but are not limited to:

- o Admission for adverse results of OPD management.
- o Admission for complication or incomplete management of a problem on previous hospital admission.
- o Transfer from a general care unit to a special care unit.
- o Transfer to another acute care facility.
- o Unplanned return to operating room on this admission.

- o Myocardial infarction occurring within 48 hours of a surgical procedure on this admission.
- o Cardiac or respiratory arrest.
- o Death.

Cases found in variance from these criteria are not necessarily representative of compromised care but are only identified for specific case review. These cases should be reviewed through the authority of the PRO. No case should be considered a "problem" until subjected to "peer review" by physician reviewers. Problems identified should be quantified and corrected under the authority of the PRO, and facilities or providers unresponsive to this authority should be subject to sanction. Baseline data established through this approach could be used to target concurrent review interventions. Finally, it must be understood that this comprehensive approach to quality review will be more expensive than the present program.

2. AMPRA recognizes that generic screens represent a first step in building a systematic approach to quality review. The next generation of quality review should incorporate severity of illness indices to move beyond strategies that can identify poor quality outcomes to methods that can measure the broad continuum of clinical efficacy. AMPRA recommends that HCFA experiment with severity measures for eventual implementation across all hospitals.

3. Quality assurance is enhanced with effective systems to monitor patient health care outcomes over time. In absence of integrated Part A and B data systems, AMPRA recommends that PROs match death data available from the Social Security system and state vital statistics with existing PRO inpatient data bases to better track instances of premature discharge and institution specific mortality rates.

4. A growing number of short hospital stays under PPS must be analyzed in light of the economic incentives to hospitals. AMPRA recommends that short stays be a component of the retrospective review sample. At the very least, a hospital with an average Medicare length of stay of four days or less should be placed under 100% review for the following quarter to identify if both quality and utilization problems exist.

5. AMPRA recommends that HCFA require PROs to undertake a developmental objective to identify quality of care issues related to new technology.

Utilization Review - With the implementation of PPS - a system based on a fixed payment per hospital admission - the review of Medicare admissions has become the central utilization objective for PROs. AMPRA members have been impressed by the research of Dr. John Wennberg revealing that significant variations exist in per capita admission rates. Practice variation represents a serious challenge to the physician community that must be better understood through data analysis, research and an active peer review program. Further, practice variation reflects the "uncertain" science of medicine and the need to involve beneficiaries in treatment decisions where medical consensus is lacking. Through the efforts of PROs, there is a great potential for improvement in quality of care and better management of health care resources.

Recommendations:

1. AMPRA recommends 100% preadmission review of scheduled or elective admissions. Experience has shown that preadmission review is a cost effective intervention, moves review away from contentious retrospective denials, and can be easily expanded. Preadmission review can be used to better identify readmissions to hospitals than the present retrospective review system because hospitals often bill out of sequence. Quality concerns uncovered through preadmission review can be dealt with immediately rather than months after treatment. PROs should be permitted, based on experience, to focus review below the 100% level. Any preadmission review program must be accompanied by some level of retrospective record review to maintain the integrity of the review process.

2. AMPRA is supportive of an appropriate Medicare second opinion program in recognition of the need to involve beneficiaries in treatment decisions. However, not all cases for a given procedure need to be referred for second opinions. AMPRA recommends a marriage of preadmission review and second opinions that would permit PROs to first apply preadmission screens and then decide on one of three possible courses of action: certify the case; deny the case; refer the case to a second opinion, leaving the treatment decisions in the hands of the beneficiary. AMPRA believes strongly that PROs must retain the authority to make final review determinations when medical necessity and appropriateness can be clearly established. For cases lacking such clarity, it is sound policy to involve beneficiaries more directly in treatment decisions through second opinions.

3. AMPRA believes that PROs should focus efforts on the documentation, feedback and analysis of medical practice variation. Small area analysis is an appropriate method for identifying such variations. AMPRA supports HCFA's advocacy of small area analysis, yet is concerned with how the methodology might be applied. HCFA drafts of the new scope of work for the second round of PRO contracts confuses small area analysis with admission rate variations by institution. Further, it implies that HCFA will provide the variation documentation and data analysis to the PRO and help target appropriate review interventions.

It must be clearly understood that small area analysis is a population-based epidemiological calculation which cannot be derived from institution or hospital specific utilization rates. Most importantly, small area analysis should be undertaken locally by the PRO with encouragement and support from HCFA. Any action plan to reduce variation should be a matter for individual PRO discretion and determination.

AMPRA recommends that small area analysis be supported by federal dollars. For a small percentage of the PRO budget, HCFA could fund the documentation, provider feedback, and analysis of practice variation in every state. Small area analysis could become an indispensable management tool and assist PROs in focusing "in" and focusing "out" review interventions. 100% preadmission review could be adjusted and modified as a result of small area analysis.

Mandated Prospective Payment Review Plan - A prospective payment review plan has been a basic requirement of the PRO program since the program's inception. Mandated reviews are retrospective in nature, applied to every hospital, and include: a five percent sample for admissions necessity; a five percent sample for DRG validation; admissions occurring within seven days of discharge; every permanent cardiac pacemaker implantation; transfers from a PPS hospital to any other hospital; fifty percent sample of cost outliers; fifty percent sample of day outliers. PROs are triggered up to a higher volume of review when "patterns" of unnecessary utilization, as defined by HCFA, are uncovered.

After two years of experience under mandated review (PSRO & PRO), AMPRA believes it is time to rethink the philosophy of mandated review. A central question must be answered: can a uniform review formula begin to address variations in hospital performance and a whole host of institution specific quality, utilization, and management characteristics? AMPRA does not believe so. No set formula could realistically address such diversity and substitute for the knowledge and expertise of the physicians and staff of PROs working inside their own communities. It was in recognition of just these points that Congress structured the PRO program to permit flexibility in the structure and design of review. A rigid review system runs the risk of burdening good performing institutions with unnecessary review and concentrating PRO energies on activities that do not yield tangible results.

The goal is to develop a flexible program that allows PRO discretion to intensify/moderate review within the parameters of a standard hospital compliance monitoring system.

Recommendations:

1. AMPRA recommends that the separate admission and DRG samples be merged into a single sample of 7.5% of admissions subject to the sample sizes for smaller hospitals. This sample would consitute the standard retrospective compliance monitoring for all hospitals under PPS. Each case in the 7.5% sample would be reviewed for quality, the appropriateness of discharge, the necessity of admission and DRG validation. An alternative would be to review a single random sample of 5% of all admissions plus a 50% sample of short stays (3 days or less).

2. An established fixed interval (e.g. 7 or 15 days) for readmission review is arbitrary, restrictive and predictable to providers being reviewed. PROs need to be assessing readmission experience at longer intervals and adjusting review appropriately. AMPRA recommends as a preferable alternative the implementation of a review system using indicators of appropriate discharge as proposed in recommendation one, and the use of those results to develop a plan for focusing readmission review. Readmission review should distinguish possible gaming issues from compromised care issues.

3. AMPRA recommends that as a basic policy outlier review be considered a quality review function. It has been PRO experience that cases leading to day outlier status, in particular, may be indicative of poor clinical management. Therefore the 50% sample should be retained but, for purposes of efficiency, it is recommended that the trigger for implementing 100% day outlier review be revised from 2.5% or 3 cases to 10% denied days of the total outlier days reviewed. AMPRA recommends that the fiscal (bill audit) aspects of cost outlier review be shifted back to the fiscal intermediary.

4. AMPRA is concerned that formulas to trigger PROs to intensify review are arbitrary and create perverse incentives since additional work was not anticipated by the original contract and not funded. AMPRA recommends that all trigger formulas be reconsidered in light of program experience and consideration given to developing a more flexible system. Such a system might allow PROs to eliminate/reduce review for same institutions when review is intensified in others. It is time to reward the good performer and concentrate energies where the yield is greatest.

5. AMPRA recommends that 100% pacemaker review be reconsidered for elimination or addressed as a quality issue in light of PRO review experience.

Data - Comprehensive, timely and accurate data is the lifeblood of any effective review system. HCFA's new data policy for Medicare review that mandates PRO use of fiscal intermediary claims data is a continuing source of concern for AMPRA members. With any new undertaking, there are problems associated with start up, particularly in the area of data accuracy and timely transfer.

Recommendations:

1. The lag time in data receipt is primarily caused by HCFA policy that allows hospitals to bill up to a year after patient discharge. Data lag complicates review, slows down needed PRO oversight of hospitals until months after patient care was rendered, and stretches out timely assessment of PRO impact needed under performance based contracts. AMPRA recommends strict enforcement of new rules governing timely submission of claims.

2. AMPRA recommends that the national UB-82 Committee mandate the inclusion of medical record number and preadmission certification number in its required data set for Medicare.

3. Because the yield is insignificant, AMPRA recommends that code editor review be abandoned and the cost of maintaining related administrative systems be saved.

4. To develop a more sophisticated data analysis capability, PROs must secure access to information systems beyond Part A claims data. Part B data, census information, Medicare eligibility data, death records, hospital and physician data need to be collected to maximize a PRO's analytic potential. AMPRA recommends that HCFA provide the funding to PROs to support access and integration of multiple data bases.

B. ADMINISTRATIVE POLICY

Contract Administration Issues - The PRO statute heralded a new age in the administration and management of Medicare review. Unlike the PSRO program that worked under a federal grant system, PRO program accountability is established through competitive bidding for performance based, fixed price federal contracts. Congress, however, recognized the difficulty of defining an absolute review "product" or "outcome" and understood that largely non-profit, physician based review organizations were not a typical federal contractor. Thus, the statute provided leeway for the flexible administration of federal PRO contracts.

After a year of experience under federal contract, PROs are concerned that HCFA has been, on the one hand, extremely rigid in applying federal contract guidelines to the PRO program, and on the other hand, extremely loose in following contract procedure. Two areas are of great concern to AMPRA members: the rigidity of payment schedules under PRO contracts that results in PRO receipt of payment 60 to 75 days after costs have been incurred for services rendered; HCFA's propensity to issue a myriad of new instructions to PROs that change significantly the original, negotiated scope of work but without the opportunity for PROs to negotiate a formal contract modification and additional review dollars. AMPRA seeks balance in federal contract administration. It must be recognized that the unique nature of physician peer review argues against strict adherence to contract rules and regulations but that a businesslike relationship betwen PROs and HCFA must be maintained.

Recommendations:

1. AMPRA requests HCFA to provide the opportunity to negotiate progress payments in accordance with the Prompt Payment Act - Federal Register, Vol. 49, No. 133, July 10, 1984, pp. 28,140, 28,141 and Contract provisions for advance payments CFR 41, 1-30, 414-2. At the very least, AMPRA recommends that PROs receive full payment for services rendered on the first day following the end of the month in which PRO costs were incurred. The recent HCFA compromise that will permit receipt of one half payment two weeks after the end of the month and another one half payment 30 days after the end of the month does not alleviate existing and potential cash flow problems.

2. Whenever there is a modification originated by regulation, transmittal, manual, instruction, etc., there must be a change order and corresponding increase/decrease in financial remuneration prior to implementation.

3. Whenever there is a change order the lead time for implementation must be mutually agreeable to contracting parties.

4. All instructions, interpretations or agreements between HCFA and the PRO must be in writing with sufficient notice prior to effective date.

5. AMPRA encourages HCFA to issue modifications in draft form to allow time for comment and assessment of financial and schedule implications.

Program Administration Issues - The PRO statute was intended to establish program accountability through the negotiation of performance based contracts. This approach would permit PROs the flexibility to reach desired outcomes through innovative review strategies. The movement towards an outcome oriented program was, in part, inspired by the perceived failure of PSROs to accomplish their mission when married to a rigid and process driven review system.

Unfortunately, AMPRA believes that HCFA is operating under the old PSRO program philosophy and has not translated the intent of the statute into a flexibly administered program. As always, too much emphasis is being placed on PRO compliance with a prescriptive set of program rules and regulations that stifle local initiative and PRO innovation. AMPRA seeks the latitude for its members to be more responsive to unique community needs and characteristics. In addition, too much emphasis is being placed on oversight of PRO activities by HCFA regional offices while a high volume of reporting requirements and contract "deliverables" leave PROs in a proverbial paper chase. AMPRA knows of no other purchaser of a review service that demands such constant scrutiny of daily activities. In the end, this approach is neither productive nor the intent of Congress. A better balance must be struck that satisfies HCFA interests in program accountability with the development of a review environment that encourages innovation and local initiative.

Recommendations:

1. AMPRA recommends that HCFA reassess all PRO reporting requirements to assure necessity of reports and to clearly define report elements and delivery dates.

2. The role of HCFA regional offices in oversight review should be defined and made consistent nationwide. AMPRA is also concerned with the inordinate time PRO staffs spend in responding to requests from other agencies: Inspector General's office; General Accounting Office; Congressional Committees; and the SuperPRO. AMPRA recommends that these oversight efforts be better coordinated in recognition of the limited resources of PROs and the need to devote maximum attention to review functions.

3. HCFA PRO policies and program modifications should be issued in draft form to all groups affected by PRO review in sufficient time to allow for comments, revisions and implementation.

4. As is the intent of the PRO statute, PROs should be judged on the basis of performance and not credentials. The requirement in the draft scope of work that RRAs and ARTs must be hired to perform DRG validation is not acceptable to AMPRA. The implied objective can be met by PROs through other means, such as active liaison with the state medical records association. For many PROs, the proposal is financially prohibitive and finding quality people may be impossible. AMPRA recommends that this proposed requirement be eliminated.

In a similar vein, HCFA should not impose any restrictions on Board composition. AMPRA recommends revision of the present PRO regulations to reflect PRO decision making authority.

C. EXPANSION POLICY

Fiscal constraints on inpatient review services created by the prospective payment system will encourage the "unbundling" of hospital services. Pressure on the prices of services by public and private purchasers is stimulating the growth of free standing health service sites. Many of the services provided by these facilities and organizations were traditionally provided by hospitals. While market forces can help restrain hospital cost increases, the proliferation of unnecessary health care services must be avoided.

At the same time, purchaser demand is accelerating the growth of provider risk arrangements. The Medicare program has expressed a long range interest in capitation systems and has created strong inducements for Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs) to enroll Medicare beneficiaries. While at risk arrangements help to moderate the utilization of health care services, the incentives may lead to instances and patterns of undertreatment.

In recognition of this changing medical marketplace, Congress, through various legislative initiatives, has voiced interest in PRO review of health services beyond the inpatient setting. AMPRA supports this initiative. Only through review of services throughout the continum of care can patient health outcomes and utilization of health resources be effectively evaluated.

AMPRA's enthusiasm for expansion of PRO activities is tempered by concerns related to implementation. In general, AMPRA believes that careful thought, planning, time, and resources must precede any movement towards outpatient review. In particular, a uniform and consistent ambulatory care data system must be developed and appropriate funding secured to assure program effectiveness. Anything less will cripple PROs in their attempt-to conduct outpatient review.

Recommendations:

1. AMPRA supports PRO review of HMOs/CMPs outpatient surgery, skilled nursing facilities, including swing beds, and home health care services.

2. AMPRA supports the recommended plan for PRO review of HMOs/CMPs developed by a working task force of representatives of the American Medical Peer Review Association/American Medical Care and Review Association/Group Health Association of America. This plan would apply generic screens to indentify quality concerns, trigger a review of ambulatory care records by screening inpatient diagnoses thought to be indicative of poor clinical management in the outpatient setting, and include a structural review by survey teams.

3. As an additional step to broaden ambulatory review, AMPRA recommends the development of a preprocedure review program for outpatient surgery. This initiative is recommended not only to protect against overutilization in the outpatient setting but, more importantly, to assure that patients needing inpatient care are, in fact, admitted to the hospital. A suggested approach to be considered would entail HCFA developing a list of the top twenty costly and frequent procedures that can be done safely in the hospital outpatient or freestanding ambulatory surgery setting. Each PRO would then select an appropriate number for pre-procedure certification. PROs would perform 100% retrospective reivew of all patients admitted to a hospital for a procedure on the outpatient list. AMPRA would also recommend some modest level of retrospective monitoring of ambulatory surgery records to assure that there is adequate documentation of necessity and appropriateness.

4. In order to effectively evaluate ambulatory care services, HCFA must develop a standardized claim form and data collection format that lends itself to utilization and quality assessment by PROs. Ultimately, the goal is the establishment of an integrated Part A and Part B data system that can be keyed by patient identifiers rather than just provider facility. Such a flexible data system would permit the tracking of patient encounters throughout the range of inpatient and outpatient services. To begin the work on this challenging assignment, AMPRA recommends the establishment of a high level Task Force of government, provider, fiscal intermediary, carrier, and PRO representatives modeled after the National UB-82 Committee. This effort should be supported by federal funding and definitive timetables should be established for work to be accomplished to reflect the urgency of this intitiative.

5. The success of any ambulatory care review system is dependent on adequate funding. AMPRA recommends that new language be added to the existing PRO statute to make explicit Congressional intent to expand present PRO activities and to set aside additional dollars for this purpose.

6. Prospective payment to hospitals, Medicare support for HMOs/CMPs and the PRO medical review program are having a significant impact on medical review services delivered to the elderly. AMPRA recommends that an intensified communication and education effort be undertaken by HCFA, consumer groups and health care associations to explain these Medicare reforms and better prepare the elderly for a vastly different health care delivery system of the future.

7. In an effort to build the science and technology of quality assurance, AMPRA recommends that Congress fund a concerted research effort into the definition, measurement and study of patient outcomes. This effort should include the development of generic quality screens, severity of illness measures, integrated data bases, and the conduct of clinical trials. Only through a careful analysis of patient outcomes can we attempt to measure the efficacy of medical intervention.

D. EVALUATION POLICY

There is no more sensitive issue to the AMPRA membership than the evaluation of PRO performance. Nothing threatens the viability of the PRO program more than the failure to articulate program expectations and the absence of a formal and comprehensive evaluation design. At the beginning of the PRO program rather than in response to political whim or expediency, we must ask the questions: What is the PRO mission? cost containment? quality assurance? the estabishment and application of norms, standards and criteria for medical practice? and How are PROs to be judged? contract compliance? adherence to a prescribed review system? outcome measures?

AMPRA's sensitivity to the evaluation issue finds its genesis in the PSRO program. We remember all too well that the failure to ask ourselves these questions and find a meaningful process to answer them was the single major factor in the program's demise. AMPRA fears that the PRO program may be headed for a similar fate. The signals are not comforting. Performance expectations remain undefined. A formal HCFA evaluation plan remains uncompleted. The SuperPRO is asked to: validate individual review determinations made by the PRO; validate the medical criteria used by non-physician reviewers; verify that non-physicians properly apply the criteria for referral to physician review. Is this how PROs are to be judged? Or are there broader issues that must be raised that strike at the heart of PRO purpose and performance?

AMPRA believes so. We must search for a better way not only to demonstrate program accountability but to build a better review future. An effective evaluation plan not only measures present performance but does so in the context of planning and developing new strategies for the future. The task is not an easy one. It will be costly. It will take time. It will be complex. But it must be undertaken immediately if we are to build public confidence and sustain physician commitment to the art and science of peer review.

Recommendations:

1. AMPRA recommends the development of an evaluation plan that must:

    - o Involve HCFA, but not be limited to HCFA, in design and execution.
    - o Represent a long term commitment; be a series of studies on many facets of performance under varying conditions.
    - o Combine a national flavor with the organizational and regional flexibility inherent in peer review.
    - o Represent an explicit statement of the expectations of PROs - expectations which are the consensus of decision makers in Congress, the Administration, the provider community and among beneficiaries.

- Comprehensively and rigorously measure performance against these expectations.
- Direct itself both to past impact and future plans. In the jargon of the evaluator, address both the summative (did it meet the expectation) and formative (why not and what can be done about it?) dimensions.
- Look beyond PRO to the results, failures and expectations of peer review generally.[1]

2. In principle, AMPRA believes that an evaluation plan should focus on the outcome or impact of PRO review rather than the process of review. This principle was clearly articulated in the PRO statute and should be reflected in any evaluation system that is established. The impact of PRO review goes well beyond the accomplishment of contract objectives. PROs should be allowed the opportunity to document and demonstrate impact separate and apart from stated objectives.

3. The effectiveness of a PRO's quality assurance activities does not lend itself to quantifiable evaluation. "Points" given for problem resolution based on "seriousness" perversely rewards areas where care is already compromised and penalizes areas where baseline care is good. Evaluation should be based to a considerable degree on the ability of the PRO to demonstrate that care can be delivered under the PPS system without compromise of quality. Increasing or unresolved quality problems ocurring at rates above national norms should be the only pass/fail measure of the adequacy of the PRO quality assurance program. This methodology will permit a broader range of quality assessment than evaluating achievement of narrow quality objectives.

4. Waiver of liability, under the PSRO and now the PRO program has frustrated peer review impact. Many years have passed since this policy was implemented, and AMPRA questions its relevance in the present "risk" environment. AMPRA can no longer support the waiver of liability policy. In the event that waiver of liability is not eliminated, PRO denials paid under waiver should count as cases denied for PRO evaluation purposes.

5. AMPRA wishes to go on record that the absence of sanctions and/or a low rate of denial is not an objective indicator of nonperformance.

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[1] Graham, Jr. Testimony before the Subcommittee on Health, Senate Finance Committee, Oversight Hearing on PRO Implementation. Foundation for Health Care Evaluation. April 19, 1985.

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Chairman HEINZ. On page 5, there is a statement that I think sums up your summation.

It says, and I quote, "The present quality assurance system required under PRO contracts is limited, restrictive, and lacks the innovation needed at a time when the incentives of PPS"—prospective payment—"raise the potential for compromised care. The imposition of quality objectives presupposes baseline data that can validate the existence of quality problems. Given the advent of prospective payment, no such data is available across a wide spectrum of in-patient care to the elderly. Only now are quality care concerns surfacing."

Dr. DEHN. I appreciate that.

Chairman HEINZ. I commend you on that statement. I believe you all believe it is accurate, and you are the experts. What I and my colleagues believe should be secondary to your expert testimony.

[The prepared statement of Dr. Dehn follows:]

PREPARED STATEMENT OF THOMAS G. DEHN, M.D.

EXECUTIVE SUMMARY

1. The American Medical Peer Review Association, representing peer review organizations (PRO's) and other physician directed medical review groups, is concerned that an increasingly competitive and efficiency driven medical marketplace may threaten the overall quality of patient care, particularly for the poor and elderly in our society. The advent of Medicare prospective payment (PPS) and the accelerated growth of health maintenance organizations (HMO's) and competitive medical plans (CMP's) underscores the importance of a comprehensive quality assurance system.

2. AMPRA is encouraged to hear from its member PRO's around the country that, for the cases under PRO review, the quality of patient care in hospitals is generally good, with no consistent pattern of compromised care. However, we are less sanguine about the future, particularly as insurmountable Federal deficits force a further retrenchment in the Government's commitment to health care services. PRO's have detected individual instances of premature discharge and clinical mismanagement. This evidence of serious harm to patients should only strengthen the public's resolve to build a strong and effective medical reivew program.

3. AMPRA believes that the quality assurance system outlined by the health care financing administration in the PRO program is a start towards developing a comprehensive review effort but must be expanded in the months and years ahead. AMPRA recommends the application of quality and discharge screens to assist PRO's in the identification of quality problems. In addition, quality of patient care cannot be assured until a wider spectrum of health care services are brought under PRO review. AMPRA asks Congress and the administration for the necessary resources to monitor and evaluate health care services in the ambulatory setting.

4. The success of the PRO program will be dependent upon sound and consistent program and contract administration. In this regard, AMPRA recommends flexibility in program design to permit PRO's to intensify review efforts for indentified quality of care concerns and relax review in those instances in which providers are performing well. New instructions under fixed price contracts must be accompanied by the opportunity to negotiate additional remuneration for additional work. PRO contract payment schedules must be moved forward in recognition of the limited financial resources of physician based review organizations.

5. AMPRA recommends the establishment of a formula and broad reaching evaluation plan. In principle, AMPRA believes that review impact rather than review process, should set the standard of measurement for PRO performance. It should be recognized that PRO impact is not only measured by problems identified and corrected but the ability to demonstrate that care was delivered without compromise of quality and maintained consistently over time.

Mr. Chairman, I am Tom Dehn, M.D., President of the American Medical Peer Review Association (AMPRA) and a practicing radiologist from Milwaukee, Wisconsin. I am also the President of the Wisconsin Peer Review Organization. AMPRA represents physician-based medical review organizations, including Peer Review Organizations (PROs) under contract to Medicare. Our Association is committed to the maintanence of a vigorous and effective peer review program as an essential component of the practicing medical profession and as a critical factor in assuring high-quality patient care.

We appreciate the opportunity to participate in today's hearing and commend this Committee for its interest in and support for the PRO program. This oversight hearing provides us the chance to examine progress in the implementation of the PRO program, to identify problems and issues that have emerged, and to consider appropriate remedies and mid-course corrections in this vital effort.

All of us are aware that a very profound change is occurring with respect to health care services. Utilization and cost data for the Medicare program and for a large number of private health financing programs reflect dramatic changes. Particularly striking has been falling rates of hospital utilization and steep declines in the rate of increase in hospital expenditures.

Medicare's own experience confirms that these broad trends are evident in the population for which it is responsible. Medicare hospital admissions in 1984 actually declined by about 200,000 from levels in 1983 marking the first such drop in the history of the program. In 1985, this declining pattern of hospital admissions gained further momentum. This occurred despite what many see as the financial incentive under PPS to increase the frequency of hospital admissions. Average length-of-stay for hospitalized Medicare patients under PPS in 1984 dropped to 7.5 days, down two full days from the previous year's average.

The question before us today, Senator Heinz, is not whether the health care system is changing. We know that. The real question is what becomes of patient care quality? Are Medicare beneficiaries to suffer from the new economic incentives of the system that reward efficiency and are they to be captives of health policy driven by insurmountable federal deficits?

In AMPRA's view, there can be little doubt that the new medical marketplace raises the potential for patient care compromise. The evolving payments systems for providers rewards the most efficient use of health care services. While greater efficiency should be encouraged in any industry and in the short term many improve quality, short cuts in health care delivery leading to poor health care outcomes must be monitored and corrected. A comprehensive quality assurance program will be needed to restore the confidence of the public in this age of cost containment.

In listening to AMPRA members throughout the country, we do not hear evidence to support a general or consistent pattern of quality abuses. However, PROs have uncovered individual problems of poor and compromised care received by Medicare beneficiaries, for cases under PRO review. The threat to quality represented by new economic incentives and the heightened competition among providers of services—both hospitals and physicians—is very real and growing and underscores the need for a strong and effective PRO program.

AMPRA congratulates the Health Care Financing Administration (HCFA) for building a start in the goal of establishing a comprehensive and intelligent quality assurance program for Medicare beneficiaries. Simply getting the program up and running within the statutory deadlines for program implementation was a major feat and should be acknowledged by the Congress and the public. However, physicians and other professionals who participate in the PRO program are very cognizant of the limitation of our present efforts. We know that PRO review is largely a retrospective review in design and lacks the ability to intervene while quality concerns develop. We know that we need to look beyond episódes of hospital care if we are to evaluate quality of care. We know that clinical management of patients before and after hospitalization is as important or more so than a review of patient care during an inpatient stay. In short, we need a more comprehensive review program and the data and financial resources to support it.

In our efforts to strengthen the PRO program, we also confront some very challenging questions that concern our definition of poor quality. We do not believe that premature hospital discharges are the only threats to quality care. In fact, the definition of "premature discharge" is not yet fully established. For example, shorter hospital stays reduce the risk of hospital-acquired infections, of medication errors, of excessive testing, and injuries from falls. Thus, longer hospital stays can have an adverse impact on quality.

Moreover, the problem of premature discharge may not be insufficient hospital services, but rather inadequate clinical management of the post-acute patient. It has been well established that the resources and support system for the post-acute patient are often inadequate or non-existent. These deficiencies in our delivery system have, to a large extent, been accomodated by payment systems that made it possible to prolong hospital stays. Now we are confronting a system in which the payment system for acute care discourages additional days in the hospital. As members of PROs, physicians must re-examine the assumptions of appropriate hospital admissions and lengths of stay.

This re-appraisal of medical practice patterns, in turn, raises issues about the expectations that purchasers and recipients of care have concerning quality. More specifically, is quality defined in terms of medical criteria alone, or should we take account of other, related factors such as the social, economic or emotional needs of patients?

There are many instances in which the absence of family support, or a caregiver, or alternate facilities, or adequate housing, or limitations in the activities of daily living give rise to treatment protocols that would not be dictated by strict adherence to medical criteria. Once criteria beyond those of medical science are applied, we need guidance from public and private interests about the extent to which these other criteria should be applied and a recognition of the effect of these criteria on the cost of health care services. We ask Congress, the Administration and the public what are their expectations?

As we seek to document and correct compromises in quality, we must also be aware of the need for beneficiary education. With the change in practice patterns and with patients discharged earlier from acute care hospitals, some patients may not have sufficient understanding of the basis of these changes and may conclude that their care has not been appropriate. It is quite understandable that a patient who did not feel fully recovered and would like some additional recuperative time in the hospital would resist accepting a discharge order. It seems that medical practice is changing much more rapidly than the general public's perception of appropriate hospital care. This chasm may be overcome with proper counseling and education. AMPRA recommends that this effort get underway immediately through a public and private sector partnership.

In some respects, the quality concerns that we all are now addressing in the wake of PPS have been with us since the beginning of the Medicare program. More prudent use of hospital services simply serves to underscore the fact that the Medicare benefit package is acute-care oriented. It is by all reports woefully deficient in its coverage of preventive and ambulatory services and in its coverage of the needs of the post-acute patient. Limitations on skilled nursing facility access and the rather narrow scope of home health benefits combined with payment reductions have resulted in Medicare beneficiaries bearing the costs of these services out-of-pocket or through supplementary insurance or simply doing without. For example, Medicare requires a three-day stay in an acute hospital as a condition for coverage of SNF care. These gaps and deficiencies in the design of the Medicare program should be revisited and corrected so that sound clinical management is consistent with the coverage policy of the program.

We recognize that in the foregoing discussion we have not resolved the many quality-related issues that we have raised. The rapidity of change now being witnessed in our health delivery system is challenging our capacity to understand, plan, and direct our activities in a coordinated and rational manner. Within the PRO program, we see the tensions and conflicts arising from the expansion of ambulatory care in a program which has historically focused on the acute hospital episode.

But some things are clear. The scope of the present PRO program must be expanded. We need to intensify our efforts to define and validate quality in a broader context. The quality objectives that are a requirement of the PRO contract are limited in scope and dificult to validate. AMPRA recommends the application of quality and discharge screens as a more appropriate mechanism to identify quality concerns and build a baseline of empirical data on quality issues. Once quality problems have been identified, PROs need the resources to intensify review before and during the provision of services. With our present emphasis on retrospective review of care, we are largely unable to intervene concurrently in the ongoing care of an individual patient.

Finally, our focus must be on patient outcomes as measured over the entire spectrum of services provided—ambulatory and institutional. Without the means to follow patients before and after acute interventions, we cannot make sound judgements about the quality of clinical management. And without other potential indicators of quality compromises beyond readmissions and tranfers, we are not in a position to assure quality of care in any settings or to determine the accountable parties when quality has been adversely impacted. Integrated Part A & B data systems will be required to support continuing care review. To accomplish all the steps that AMPRA has outlined here, it should be recognized that significantly more dollars must be invested in the PRO effort.

Recently, AMPRA convened a task force composed of representatives from PROs to examine our present condition and to prepare our future agenda. The report of this task force, which is appended to this testimony, includes our analysis and recommendations for the future direction of physician peer review programs. The report responds to each of the six specific areas that you requested AMPRA to address in our testimony. The recommendations are focused on the PRO program, but in our view are also applicable to all review programs aimed at assuring the quality of patient care in any sector.

At our recent Board meeting, this report and its recommendations were adopted as the official policy of AMPRA. We believe these recommendations are clear and achievable and we are committed to advancing them in the public policy debate over the future of the PRO program. We ask for the Committee's support in this endeavor.

Mr. Chairman, we again want to thank you for your interest and support of physician peer review and for the promotion of quality health care. We look forward to our continuing work on these issues with you and your Committee. We would be pleased to respond to any questions that you or other members of the Committee may have.

Chairman Heinz. If you have basically summarized, Dr Dehn, let me proceed to invite the other members of your organization to make brief comments to the questions in the nature of their testimony.

Let me start with Dr. Platt.

Dr. Platt, I understand that the Colorado Foundation for Medical Care PRO has been in existence for a decade, and operating as a PSRO prior to the prospective payment system. Were you able to monitor quality of care any more effectively under the old PSRO system than under the new rules, and why?

STATEMENT OF DR. KENNETH A. PLATT, MEDICAL DIRECTOR, COLORADO FOUNDATION FOR MEDICAL CARE, ACCOMPANIED BY ARJA ADAIR, EXECUTIVE DIRECTOR

Dr. Platt. Well, Senator, that is a good question. I plead guilty not only to being involved in this for a decade or more—and that is why my hair has turned somewhat lighter than yours—but I also was on a PSRO National Council for 3 years. And although that was not considered to be a program that was effective because it was not quantifiable, it was more effective in some degrees than PRO, because it was more flexible. So that a flexibility of the PSRO Program allowed us to do things that we are restricted under the PRO Program. And those comparisons merely emphasize a plea for flexibility that you have heard from everybody that has been here—the recipients of care, the providers of care, and now the monitors of care. Everybody is saying, "Be flexible. Give us a chance to focus. Give us a chance to look at quality in a broad spectrum of cases." The flexibility issue is a key issue if you are going into a quality assurance program.

Chairman Heinz. What you are saying is that the PSRO's allowed you more flexibility, and you could do a better job on quality of care. Is that what you are saying?

Dr. Platt. We had an opportunity to be more flexible in the entire approach to review. But again, we were not quantifiable.

Now, one of the problems you ran into when you stepped into the PPS system and the PRO program is that the people out of HCFA felt they had to monitor the program by numerical qualifications. They had to come up with figures that justified our existence. And that is one of the rigidity problems you ran into. We think that was an error, and I think it should have been focused from the start. But basically speaking, we had to live with what we were given.

Chairman HEINZ. By the way, I want to note that each of you—Dr. Sherrill, Dr. Crisafulli, and Dr. Platt—have submitted testimony for the record, and all of that testimony will be a part of the record; please rest-assured of that.

[The prepared statement of Dr. Platt follows:]

PREPARED STATEMENT OF KENNETH A. PLATT, M.D.

Mr. Chairman, members of the committee and interested parties, I am Kenneth A. Platt, M.D., family practitioner from Westminster, Colorado, and medical director of the Colorado Foundation for Medical Care. It is our pleasure to have this opportunity to provide the position of the Colorado Foundation for Medical Care in response to the six issues raised in Senator Heinz's letter of September 16, 1985. Prior to addressing these items, we would like to reaffirm to the committee our appreciation of the difficult task faced by Congress and the administration to assure the appropriate expenditure of health care resources to the portion of the U.S. population covered by Medicare services. CFMC, as an organization which was one of the initial conditional PSRO's in 1974, has, along with your committee, seen a variety of changing stimuli in the health care area. CFMC has been a participant along with many other physician organizations in working with the Health Care Financing Administration as HCFA has sought to make the dramatic change from the PSRO review of over 160 organizations nationwide to the letting of contracts to over 50 PRO's prior to November 15, 1984. HCFA is to be complimented on the steps taken and the tasks completed despite tremendous pressures concerning the interpretation of congressional direction, the controversial nature of the prospective payment system and the ramifications of an economically driven system of health care recognizing the balancing act required to insure accountability yet offer flexibility as provided by the PRO law. CFMC welcomes the opportunity to provide its thoughts on the current administration of the PRO program, the PRO program accomplishments to date, and the constructive thoughts to help make an even stronger program of assuring both appropriate quality and the expenditure of Medicare health care resources when medically necessary and appropriate. Towards that end, let me provide responses to your questions in the order which they were asked.

Item 1: Observations and recommendations on what is needed to assure quality of care and protect Medicare patients from substandard care. The current PRO program is built upon knowledge gained from the prior twelve year's experience under PSRO. As you know, flexibility was encouraged under the PSRO program to permit recognition of differences among States or between urban and rural areas. The current PRO contract is very proscribed in its requirements. The majority of the effort is financially allocated to utilization review assuring that hospitals and physicians are not gaming the DRG system, assuring that only medically necessary services are paid by Medicare and assuring that quality review occurs in the five mandated areas. As you know, HCFA's initial position was that one or two of the quality objectives would be selected. The final request for proposal indicated all five. While the emphasis on quality is a start in the right direction and we comment HCFA on the establishment of a pilot project to permit additional work on readmissions beyond the current mandated seven day readmission requirement, the CFMC is of the opinion that additional resources could be wisely used in addressing quality of care. We believe that adding to the current utilization review components of admission review and DRG validation, a required discharge screen and quality screen with the legal authorization to permit a PRO to monitor when clinically indicated the "after care" beyond hospitalization or to review care provided prior to hospitalization which led to an unnecessary hospitalization, would permit a physician PRO to correct circumstances which may have led to substandard care. The biggest return on the investment would be to permit the PRO's to review cases on a sample basis and then to provide the flexibility to continue the monitoring or evaluating of care either prior to or after hospitalization in order to assure that Medicare beneficiaries are receiving appropriate care.

In summary, if care is given that is inappropriate to the clinical condition of the patient in the hospital; if the timing of patient discharge is inappropriate; or if the care given prior to hospitalization is inappropriate; a flexible system of addressing these concerns with resources that permit this to be accomplished will provide the strongest mechanism of assuring appropriate care for Medicare beneficiaries. Today, under current legislative initiatives and funding requirements, PRO review is compartmentalized, and given the emphasis on the cost of the Medicare Program, strongly based on utilization concerns.

Item 2: Problems and deficiencies in the CFMC Program for quality assurance and how these problems and deficiencies may be overcome and corrected. The CFMC's position on this question is a mirror of the comments made concerning the PRO Program. The appropriate mechanism to address quality concerns is not through a proscribed review format but through a proscribed screening process which then allows flexibility for a PRO to address quality concerns over the total spectrum of care where those concerns are identified. Quality issues are not only physician generated but may be generated by hospital professional staff, nursing, etc. Recognition of quality concerns generated by other than physicians would be appropriate.

Item 3: Flaws and deficiencies in Federal regulations governing the programs, goals and structure of the PRO's and how these flaws and deficiencies may be overcome and corrected. The Health Care Financing Administration has done a superb job in implementing a most controversial program which has, in combination with prospective payment system, dramatically changed the economic incentives of the delivery of health care to Medicare beneficiaries. While there are a number of items which might be discussed here, in the interest of your time, we would like to limit our discussion to four items. As we have previously mentioned, the Health Care Financing Administration has had an awesome task of implementing both the PPS and the PRO system. In the field, this task has been more difficult for all involved for two reasons. One, the timeliness of the receipt of instructions which in several instances have led to implementation requirements within five days of reciept or implementation requested prior to receipt of instructions. Second, the timing of receipt of instructions among the actors—hospitals, fiscal intermediaries and the PRO—where timing discrepancies as large as two months have occurred. We recognize that this is a very complicated program, with pressures on the administrators of this program from both the administration, the Congress and other interested parties. We look forward to an improvement in both the chronological expectations of the Health Care Financing Administration as well as the coordination among the actors of this process.

The second item we wish to address is flexibility. While the intent of the PRO law provides for the potential of flexibility, thus far, the administration of the program has minimized that potential. Where the PSRO Program provided for innovation and flexibility, both PSRO's and HCFA paid a price when the time of accountability to Congress and the Office of Management and Budget occurred. The effectiveness of PRO's can be improved through allowing flexibility in review processes and permitting allocation of resources to identified problems, instead of specific mandated review requirements.

Third, the issue of the educational process from the Federal Government and its contractors, providing beneficiary education and assuring that there is a coordinated voice from the Social Security Administration, fiscal intermediaries and PRO's so that a beneficiary learns from all parties that their medical benefits are a set number of days per year but only days that are medically necessary. The viability of private sector review is to a large extent anchored by an effective educational process prior to the implementation of a review program so that employees/dependents know of the efforts being made by their employer to assure that resources identified for paying for health benefits are paying for only medically necessary services. For fiscal intermediaries and the Social Security Administration, a more coordinated effort in beneficiary education consistent with the PRO law is needed.

As a final input, we believe that the implementation of the prospective payment system and PRO review has dramatically reduced the utilization of the Medicare Program. While these are not the only two stimuli effecting health care utilization in this country today, for Medicare they are two very important items. For fiscal accountability, the Health Care Financing Administration has placed a strong emphasis on reductions in admissions, changing inpatient care to outpatient care, and assuring appropriate quality. Recognition must be made that continued reductions in lengths of stay or rates of admission will not occur from year to year. The greatest fear of the medical profession and those related to the provision of medical services in this country is that once the fat is out of the system, payors will continue to press for greater cost efficiencies without recognizing that they are compromising quality.

Accordingly, we believe that the emphasis, once appropriate utilization has been assured, should insure that Medicare beneficiaries are receiving appropriate services for their needs in the appropriate location and are not being discharged too soon or not being admitted unnecessarily. We see that the cost to the Government of continued monitoring of the appropriateness of care will not result in a continued ten or fifteen percent reduction in lengths of stay or rate of admission, but will assure that dollars being spent are being spent for appropriate services. Accordingly, accountability of PRO's and similar organizations involved in these efforts will need to be looked at from a different prospective. Physician review organizations will then assure that appropriate quality of care is being provided, at a level of utilization appropriate to the patient's needs.

Item 4: Flaws, deficiencies and inequities in CFMS's contractual arrangement with the Health Care Financing Administration and how these flaws, deficiencies and inequities may be overcome and corrected. The foundation has perceived several areas of improvement in this contractual arrangement with the Health Care Financing Administration, one of which has already been acted upon by your Committee. We are pleased with the planned improvement in the cash flow situation given the fact that the fixed price contracting arrangement provided no opportunity for the cost of working capital for the provision of PRO services by this nonprofit, private corporation. We believe that your proposed legislation is a step in the right direction and congratulate you for taking such action.

As you know, each of the PRO's are coming to a renegotiation of its first two year contract. We look forward to this renegotiation providing time for more consideration of the review issues, more flexibility in the review process and a less rigid manner of contract negotiation.

Secondly, we also look to an improvement in the interpretation of fixed price contracts as compared to the previous PSRO cost reimbursement contracts. The current HCFA Program administration requires implementation of transmittals with subsequent submission of PRO identified cost increased and negotiation after the incurrence of costs. CFMC, working within the system, has incurred additional costs at the instruction of HCFA by being required to implement changes prior to agreement of cost recovery. We have done this once and question accommodating future HCFA requests prior to knowing that recovery for new costs will occur. As you know, these fixed price contracts are for a stated dollar amount with a variable review volume based on intensification of review. We commend HCFA in requiring greater accountability for the usage of taxpayer money, but we cannot subsidize PRO workloads without restricting our capability of providing review and certainly cannot assume any additonal scope of work without financial acknowledgement and remuneration.

Thirdly, just as the CFMC uses five regional offices in the State of Colorado to professionally and administratively manage our review activities for all of our contracts, we believe the Health Care Financing Administration is to be congratulated on their usage of their regional offices to permit the timely, professional and administrative management of the PRO Program nationwide. The success of peer review programs is not based on WATS lines or mail service, but on the availability of individuals able to meet and address items of business with the providers of care. Given the geographical expanse of Colorado, the CFMC's effectiveness is dramatically improved through the use of regional offices. Similarly, a HCFA organizational framework which strongly utilizes regional offices will greatly improve the productivity and process of communication in assuring a good working PRO program nationwide.

Item 5: Flaws and deficiences in the PRO Program as they relate to the continuation of care following hospital discharge and how these flaws and deficiences may be overcome and corrected. As you know from a review of the current PRO contract deliverables, after care following hospital discharges an area which to date is not a part of PRO review. By contract, we do not know of any PRO looking at the care provided at home with or without home health care, or in residential care facilities. Skilled nursing home coverage by Medicare is governed by review restrospectively by the fiscal intermediaries and by certification of State health departments. As a suggested step to address care provided after hospital discharge, CFMC would recommend the use of a broad sample review providing resources for both review of discharge plans prior to hospital discharge, the discharge screen we previously spoke of; the use of a broad quality screen to assure that patient discharge is occurring after appropriate services have been delivered in the hospital; and then a sample review of discharged patients providing review in the residence of the patient to assure that they are receiving appropriate care following discharge. Although the sample would be taken from the entire Medicare population, there are certain clinical areas such as COPD, rehabilitation of fractures of a major weight bearing joint, which could provide for standardized reporting and PRO accountability. We believe that the lack of attention in this area should be corrected. Assurance that Medicare beneficiaries are receiving appropriate services subsequent to hospital discharge is a service that can be provided by PROS.

Item 6: Problems and deficiencies in the Health Care Financing Administration's overall administration and evaluation of CFMC and its program policy, procedure and practice and how these problems and deficiencies may be overcome and corrected. The CFMC would like to compliment the Health Care Financing Administration in providing direction and constructive criticism in PRO operations from HCFA's regional office.

We are corporately of the opinion that our Denver regional office provides a valid service which is very useful in assuring the correct administration of the program. Given the controversial nature of the PRO program, we are aware of the desire for assurances that the administration of the PRO program is being performed consistently. Toward that end, over the last several months, the CFMC has met with representatives of the inspector general's office from Kansas City and Chicago; and has, as every PRO has, provided four hundred records to systemetrics, the super PRO; has been audited monthly by the HCFA regional office; and is now being audited by a registered record analyst out of the regional office. While we have no objection to opening our doors and providing access to the innerworkings of our corporation, we wonder who is going to have the final say concerning whether we are operating correctly. The Health Care Financing Administration has been working on an evaluation document with the intended use of determining which PRO should be offered an opportunity to bid for a two year extension. Currently we understand that this document is in draft. Today, we are in the thirteenth month of our contract performance and, since the first day of our contract, have been performing review. Given the recognition that medical care is an art and a science and not just a science, we do wonder who will have the final say concerning the correctness of our activities and upon what basis we will be evaluated in final form. We hope the second two year contract will have adequate time for each PRO to know the standards by which they will be evaluated and that the need for flexibility in review services will not be stagnated by the desire to have consistent accountability for each and every PRO without recognition of individual review needs.

As a final item concerning accountability, much has been said concerning the volume of sanctions in the new PRO Program versus the old PSRO Program. While we agree that each PRO should be judged on its ability to identify problem hospitals, physicians or other health care practitioners who are unable to meet professionally recognized standards of care in the delivery of health care services, we also believe a second item of accountability should be incorporated. CFMC philosophically and by board policy is required to work with problem practitioners/providers in order to correct deficiencies prior to taking sanction steps. We believe recognition of the identification of problem providers and the correction of problems is just as important as recognition of the number of sanction cases brought forward.

Mr. Chairman, members of the committee, it has been our pleasure to have the opportunity to provide you our insight into the operation of one PRO's performance on the issues which we see in program administration and, most importantly, in assuring quality of care. We provide these comments in the spirit of constructive improvement. We again commend the Health Care Financing Administration in having completed as much of the job as it has in such a short period of time, and we look forward to all of us working together to strengthen the peer review process to assure that services being provided are medically necessary and appropriate to Medicare beneficiaries. Thank you.

Chairman HEINZ. Dr. Sherrill, in your written testimony, you suggested that PRO's are not funded to do comprehensive quality-of-care review. But here in Washington, many of us have marveled at HCFA's economy in negotiating the PRO contracts.

I think HCFA's contracts officer received a $3,500 bonus for doing this, in fact. And as you explained, HCFA was very stingy during their negotiations with Alabama Quality Assurance, too, cutting some $1 million from your proposal.

How did they determine the amount they could cut safely from the proposal, and were you able to absorb those cuts in your budget?

Dr. **Sherrill**. Although I worked with the Alabama program, I am primarily concerned with the medical end, and I would rather that particular answer be given by the Administrator of our program Mr. John Miller.

Chairman **Heinz**. Excuse me, gentlemen. I am turning the panel temporarily over to Senator Wilson. The single bell means that there is a vote on. I will go and vote, and hopefully, Senator Wilson will not have to recess the panel. If it gets close, he will have to, but I should be able to avoid a lengthy recess.

Thanks very much Senator Wilson.

Senator Wilson [presiding]. Go ahead, Doctor, and complete your answer.

STATEMENT OF JOHN W. MILLER, CHIEF EXECUTIVE OFFICER OF THE ALABAMA QUALITY ASSURANCE FOUNDATION, THE PRO CONTRACTOR FOR ALABAMA

Mr. **Miller**. Mr. Chairman, in response to Senator Heinz' question, at the time of contract negotiations, we were unable to present the results of the reduction in contracting. We were essentially told, "This is the money that you are going to have to work with. You are going to have to do the best you can."

As a result, we had to cut several positions from both our utilization and our quality review departments. I think we cut approximately 10 positions from our quality review department as a result of the shortfall in funding.

That was a rather specific question, and that is the specific answer.

Senator **Wilson**. Could you tell us why it was that you would cut these positions from the quality review, rather than utilization review?

Mr. **Miller**. I did not cut the key positions. I cut the review coordinator positions that we would have used to do additional prescreening on charts prior to referring to our quality assurance committees for determination of quality of care.

I also did make cuts from the utilization review department. We had to make cuts in both.

Dr. **Dehn**. Senator, in fairness, I think in general, the bidders for the PRO contracts were fairly clear on the fact that the program had a bias toward utilization review, and in cuts were to be made, they were, in order to get the contract, ordinarily made in what is considered to be the softer area, and that is quality review, and we are very uncomfortable with that.

Senator **Wilson**. Well, all right. Dr. Dehn, let me ask of you and Dr. Platt what I think is an appropriate second question. In the overall range of activities that are required of the PRO's by HCFA, where do you think that quality assurance ranks in terms of the resources that are designated for quality review and in HCFA's ratings of PRO performance?

Dr. **Dehn**. Well, if there are two, it is definitely No. 2. I would have to defer to Ken on his opinion.

Dr. **Platt**. Well, I think the emphasis from the start of a monitoring program under PSRO and PRO has always been on utilization and not on quality. And I say that not in necessarily a critical comment, but to emphasize the fact that quality review is exceedingly complex. It is a soft area even in how do you do it. It is extremely expensive. It does not give you the bang for the buck that utilization review does. I have absolutely no concern with the Federal Government's wanting to emphasize initially utilization, because utilization appeared to be out of control.

We now, however, and in our testimony have pointed out, we have reached a point where the doctors in this system—I am talking about the review system—as well as the doctors in practice are worried that if we go further in this cut on utilization, we then will get into that gray soft area known as "quality," and the patients ultimately cannot help but suffer.

And what you are hearing from AARP, what you heard from the witnesses earlier this morning, and what you are hearing from us as review organizations, we think we are at that critical precipice at the moment. And if we are going to go further in review, we need to stretch into the soft area while we are cutting back on the clear area, so that we can guarantee that we do not jeopardize quality.

Senator Wilson. Let me ask Dr. Dehn, in light of that, and in light of the comment that you made earlier, that the physician who, even if urged or counseled by hospital administrator to make what, in his professional medical judgment, is premature discharge, in your judgment, you say that physician must abide by his own judgment; if he fails to do so, he is guilty of malpractice–what I guess I have heard from the panel that preceded you is that they do not feel that the entire procedure is adequate in terms of allowing them to go forward with their best medical judgment. I believe one of them at least said he got tired of fighting.

Now, is the problem that there is simply too much fighting required for a physician to exercise what he has taken a Hippocratic Oath to exercise, and that is his best judgment, to give the best care possible?

Dr. Dehn. I am interested in the etiology of that fight, Senator. And to answer your question, I can understand that that particular physician would be disgruntled with all the pressures that are on him.

The question is where, really, the pressures are coming from. It seems to me again, and I want to reiterate, that the description of the system that we heard from that physician was that he was receiving pressure from the hospitals to economize on health care and that is to discharge his patients at a particular time or not to admit soft admissions.

That seems very difficult for me to deal with, and I would think for you, also, in a hospital program that, as I said earlier, claims to be making 8 percent profit on the DRG reimbursement system. It is not the PRO that is harassing this physician; it is the hospitals and the interrelationship between the hospital and the physician that seem to be causing the most angst in the system.

In fact, the PRO would have liked to have worked on behalf of that and the earlier physician—who in his best judgment disagrees with the pressure from the hospital, the request from the hospital to discharge his patient, it is his right while the patient is in the hospital to call the PRO; we will, within a few hours, enlist a physician, adjudicate the decision, and prevent the potentially untimely discharge of any patient.

Senator **Wilson**. So you are saying that physicians are unaware that the PRO's exist as their friend, and that as the advocate for the beneficiary, you are available to them to resolve not only an internal dispute with a hospital, but also to protect them from the kind of pressures they are feeling to justify the HCFA, through these—another of the panelists said he spent a great deal of time trying to compose the appropriate paragraph for the chart, for the record, that will ward off a later, time-consuming investigation by HCFA.

Dr. **Dehn**. Well, I think you are absolutely right. I think that all of us have a job to do in terms of provider education and physician education with regard to the PRO. We carry the stigma, because we are funded by the Federal Government, of being agents of the Federal Government. We are not agents of the Federal Government. We are advocates of a system that delivers quality care at the lowest possible price on behalf of the beneficiary. I think we have a job to do in terms of educating physicians, and we have a job to do—an enormous job to do—in terms of educating the beneficiaries on what their rights are, and how to use our system.

Senator **Wilson**. Mr. Lynch?

STATEMENT OF EDWARD J. LYNCH, EXECUTIVE DIRECTOR, RHODE ISLAND AND MAINE PRO

Mr. **Lynch**. I would like to respond to your concern, Senator, about malpractice and the implications of malpractice to the DRG system, the PRO program.

First of all, it is very, very difficult for a PRO, I think, to be considered a friend of a physician who might be delivering some substandard care.

No. 2, I think in terms of malpractice, that consumers, the people of the United States, are becoming much more sensitive in terms of the type of medical treatment they are receiving at the hands of their physicians. As a result of that awareness, not necessarily the DRG system, but as a result of their awareness, they have gone to their attorneys and said, "This has happened to me," and obviously, litigation is on, and the large jury awards result.

I have had a special interest in malpractice in that I feel the eventual resolution of the problem will be through peer review, and someone a lot smarter than myself is going to come up with a system to merge or link peer review activity with malpractice.

Dr. **Dehn**. Dr. Platt has a comment.

Chairman **Heinz**. Let me thank Senator Wilson for chairing the hearing in my absence.

Dr. Crisafulli, how different are quality of care reviews compared to utilization reviews in terms of cost and staff time spent per case once a potential problem case is identified?

STATEMENT OF DR. FREDERICK S. CRISAFULLI, F.A.C.P., PRESIDENT, HEALTH CARE REVIEW, INC., PROVIDENCE, RI

Dr. **Crisafulli.** I think if you separate the two systems, the costs are probably comparable. If you try to make the system as efficient as possible, you can link the two together.

For example, if you have a chart in front of you that you are reviewing for utilization purposes or for some other reason, then you would also look at it for quality purposes. The initial review would be done by the nurse; if she sees a difficulty with the quality of care provided, that can then be referred to a physician, who might at the same time be the physician who would have looked at it for utilization purposes.

So you can streamline the approach.

[The prepared statement of Dr. Crisafulli follows:]

Prepared Statement of Frederick S. Crisafulli, M.D., F.A.C.P.

INTRODUCTION

I am pleased to appear before the U.S. Special Committee on Aging today to discuss the Professional Review Program, the medical review agent for the Medicare Prospective Payment Program.

As a practicing physician, I have been active for a long period of time in the peer review process in Rhode Island. Currently, I am the president of Health Care Review Inc. having been elected this year to that position. In addition, I have served as chairman of the utilization review committee, as vice president of the corporation, and as medical director. I have also served as delegate to the Americal Medical Peer Review Association (AMPRA) and have served as a reference committee member. I am also associated with the Brown University medical program as a clinical assistant professor of medicine and have been a fellow in the American College of Physicians since 1977. This catalogue of references, Mr. Chairman, is only presented to you as an indication of my deep concern about the delivery of medical care and the review of that care.

PPS AND QUALITY REVIEW

At this time, I perceive the PRO programs as the sentinel of the prospective payment system by diagnostic related group (DRG) for the Medicare Program. This sentinel effect is not only perceived by me to directly relate to utilization review but also to quality review. In fact, it is only recently that the issue of quality of care has been raised in any realistic sense. The five quality studies delineated in the request of proposal (RFP) by the Health Care Financing Administration (HCFA) and mandated for each Professional Review Organization (PRO) are certainly appropriate as far as they go—but I, personally, do not believe that they go far enough in assuring the quality of care for Medicare beneficiaries. In my judgment, after a year's medical review in the State of Rhode Island, and almost a year in the State of Maine, there is a clear need for a case-by-case review of medical charts for quality purposes. This quality review process, of course, is being carried out for patients who are readmitted within seven days of discharge where inadequate care has been provided during the first admission. Patterns of poor care, or substandard care, provided by physicians and/or institutions can only emerge and can be only evaluated by a case-by-case review of the quality of care delivered to the individual Medicare beneficiary.

The bottom line issue in reviewing quality of care, to my way of thinking, is the identification of substandard quality of care. As a practicing physician, I am not so much interested in rates of procedures performed, or in establishing performance objectives for bureaucratic reasons, as I am interested in assuring that the care is medically necessary, appropriate, sufficient, and effective in treating the patient.

As the Professional Review Organization (PRO) in Rhode Island and in Maine, the approach taken by Health Care Review Inc. is one that views quality of care from the individual case perspective. Health Care Review Inc. has developed an intervention system short of sanctioning. We, as a physician organization, do not support a punitive approach to improving quality of care, except in the most flagrant of cases or where a pattern of serious problems has emerged. Naturally, a case that falls into the category requiring consideration of sanction is treated differently from a problem that has been identified as "non-serious".

Such an approach by Health Care Review Inc. currently relies upon a linkage with cases reviewed for utilization and for other purposes, that is, a case identified for utilization purposes is also looked at for quality purposes; subsequently, this case is referred to the quality review department of our corporation where further action follows. An outline of such a quality review protocol for the States of Rhode Island and for Maine, are enclosed as attachments to this statement.

RELATIONSHIP BETWEEN QUALITY AND UTILIZATION

For your information, the utilization physician of the Professional Review Organization (PRO) can easily function as a quality review physician unless special medical expertise is required.

Such a spin-off from the utilization review to quality review arises from, in my judgment, the necessity of inadequate funding. We have been unable to pursue a high level quality of care program which would require sufficient funding to employ additional registered nurses and pay the monies necessary for quality review by practicing physicians. The need for such a program would be also the ability of the Professional Review Organization to track cases, identify patterns of care with respect to physicians and/or institutions that emerge under observation and, obviously, this type of review would demand additional non-physician and physician staff time.

Thus far, Health Care Review Inc. has not tackled the issue of establishing criteria for a pure quality review program because this process would involve a massive undertaking to cover all conceivable diagnostic and therapeutic intervention.

Although this would be an optimal way to identify areas where a consensus was developed with respect to a medical workup and medical treatment, such an approach would require a substantial amount of time, energy, and funding. I would envision the development of a pure quality review program by the medical profession in the United States as requiring years of work and development. In the interim, however, quality issues do arise and are being tackled as best as we can on a limited budget, on a case-by-case basis. Health Care Review Inc. has been focusing on problems falling into the following categories:

1. A lack of provision of a service that is medically necessary
2. The provision of a service—diagnostic or therapeutic—which is not indicated
3. The provision of a service that is inappropriate.

The clear establishment of criteria to deal with these types of problems is not, yet, possible with the funding available to Health Care Review Inc.; the Congress ought to consider a national research effort.

It is self-evident that once a quality problem is identified there needs to be verification of the problem and an assessment of the scope of the problem. Currently, there is insufficient funding to carry out this step which requires intense review and analysis of data. Once a problem is verified, an intervention strategy must be developed. The nature of the intervention depends upon the Professional Review Organization's assessment of the nature of the problem, and what corrective action would reasonably address the issue. Although the sanction process is a reasonable way to deal with issues related to a gross and flagrant issue or lack of care, and with situations of fraud and abuse, our judgment leads us to believe other types of corrective action may be more appropriate and effective.

In situations where a quality issue arises, and is related clearly to an educational problem, a medical strategy should be one of general educational intervention with subsequent monitoring and tracking of the physician, and/or the institution. In certain circumstances, the issue is not physician related so much as it is institutionally-related. This has been clearly indicated in peer review throughout the last ten years. As an example, I offer you the case of a woman treated at an exempt psychiatric institution where her medical problems (namely, significant lung disease) were not attended to. It may be that under such circumstances no adequate policy exists for coverage of medical issues while psychiatric treatment is being provided. Yet, this type of problem emerges under intensive quality review on a case-by-case basis by a Professional Review Organization.

THE IMPAIRED PHYSICIAN

Nowhere is there a provision made for dealing with quality issues that arise, however, from an impaired physician.

This is a new wrinkle that has entered the peer review process. In Rhode Island, Health Care Review Inc. is attempting to establish a linkage with the Rhode Island

Medical Society which has developed an excellent program of dealing with the impaired physician, and has, apparently, been successful in having physicians retire, undergo additional training, and take other avenues to assure quality of care in the State where a problem has been specifically identified with an individual physician. Such an approach on the local level, in my judgment, is very beneficial and is something that the Medicare Program might review carefully. Confidentiality rules, however, may preclude our involvement in this process.

As I am sure that you are aware, Health Care Review Inc. is basically reviewing the Medicare population, and then, again, only inpatient hospital treatment. When one looks at the entire spectrum of medical care delivered in the United States, the picture shows a clear fragmentation of any concerted, united effort to measure the utilization and quality of the people of the United States. For instance, patterns that emerge in the Medicare population may also reflect poor quality of care given in other populations as well. Yet, the lack of a single, intensified, vigorous medical review appears not be available at this time. There is no doubt, for instance, that in Medicare part B, where a potential problem has been identified in part A, is not subject to intensive peer review. Under such current circumstances in the United States, it appears reasonable to link identified issues across third-party payors for purposes of eliminating both utilization and quality problems. Only doctors can do that.

If my presentation appears somewhat discursive, that is because Health Care Review Inc. of Rhode Island and Maine is still on the cutting edge of peer review, and my particular ideas regarding the review of quality are still evolving. One peer review program in Rhode Island and in Maine has evolved to the point where we are beginning to identify cases, and are beginning a process of interacting with attending physican through peer review, and also intervening in a fashion to assure Health Care Review Inc. that the type of quality issues identified will not be likely to occur in the future. It is useless to identify a quality problem in peer review and then have the problem reoccur endlessly without resolution. This would certainly not benefit Medicare beneficiaries who are entitled to the economical delivery of their medical care without compromise on the quality. I strongly believe that, as a practicing physician, this should be the intent of any quality program.

Before concluding, I want to point out to the committee that the major impact of any quality program will be its sentinel effect on the practicing physician. The PRO Program must continue to function in a credible way; that is, credible to physicians, it cannot be seen as a bureaucratic tool or Government weapon to bring physicians to task. Physicians, in general, are not satisfied with the type of quality program mandated by the prospective payment system, which, in a way, tends to look from a national perspective at issues of quality; that is, from Washington's perspective downwards. Most physicians with whom I have dicussed these issues express to me that a better approach would be to look at the issue of quality from the local perspective upward: That is, by a case-by-case review and then scrutinize the patterns of substandard care as they emerge. In my judgment, a substantial credibility and visibility will be given to the PRO system if there develops a clear commitment by Medicare to review cases on an individual basis and to support this type of review with adequate funding for additional physician time and staff people.

Before concluding, Mr. Chairman, I want to express my gratitude for being able to appear before the committee to discuss this proposal for quality review for Medicare beneficiaries being monitored by the Professional Review Program.

Thank you.

Chairman HEINZ. Dr. Sherrill, what about your operation in Alabama?

STATEMENT OF DR. ROBERT G. SHERRILL, JR., MEDICAL DIRECTOR, ALABAMA QUALITY ASSURANCE FOUNDATION

Dr. SHERRILL. We have a little different operation than in many areas of the country in that we place a much greater emphasis on preadmission review. We have what we call 100 percent preadmission, that is, that we try on the elective cases, to perform a preadmission screening. We have the physicians call in, or the hospitals call in, or the physicians' offices call in for them, giving us certain information. If that meets our screen, then the patient is automatically approved for admission. If it does not meet the screen, then it must be looked at by a physician who is immediately available. He immediately takes that information and then reviews it and may say, "Yes, we can go ahead and admit this patient." Or, he may say, "Well, there is not enough information here, I need additional information," and pickup the phone and call the attending physician to clarify the patient's situation.

Frequently, we feel that we can affect a decreased utilization by screening out those cases that would be inappropriately admitted for diagnostic evaluations or workups. This is the majority of patients that are now not being admitted to hospitals.

The patients that really need to be admitted should be certified by physicians that do the screening. Our physician screeners are all practicing physicians. They are practicing everyday. They give up 3 hours, 5 hours, whatever time they carve out to do this review. The rest of the time, they are in practice.

So, whatever policies and procedures we follow, they must follow as a physician also. We review our reviewers, not only in their work in-house, but also their work, when they have a patient that needs to go into the hospital, he gets screened just the same way—and we do have denials on our own physician reviewers at times. So the system does work from that standpoint.

We also feel that in Alabama, we can pick up—through preadmission review—some quality issues, because when our physician reviewer talks to a physician who is about to admit a patient or who has just admitted a patient at midnight last night, and we are reviewing it the first thing in the morning. A physician reviewer may feel that the attending physician does not know what is going on with this patient; he does not have a very good program or treatment outlined. This raises a red flag, and we may say, "Well, we will want to see that chart when that patient is discharged, so that we can evaluate that for quality." Or, we may pick up a patient that apparently is going to use a form of therapy that is inappropriate for the diagnosis that he has made on this patient, so this would raise a flag. So there are several areas that we can find that would help us focus a little more on quality, and we do look at these and followup.

Then we order that record, have it come back, have that particular physician who raised the problem review it. If he feels there are any additional problems, or it does represent disquality, then we may pull a sample of records on this physician.

[The prepared joint statement of Mr. John Miller and Dr. Sherrill follows:]

PREPARED STATEMENT OF JOHN W. MILLER, CHIEF EXECUTIVE OFFICER OF THE ALABAMA QUALITY ASSURANCE FOUNDATION, THE PRO CONTRACTOR FOR THE STATE OF ALABAMA AND MEDICAL DIRECTOR OF THE FOUNDATION, DR. ROBERT G. SHERRILL, JR.

I. The foundation as the PRO for Alabama is fairly unique in that, after study of the prospective payment system, the foundation concluded that elimination of unnecessary admissions and protection of the Medicare beneficiary from disquality medical care would be our twin goal in bidding for the PRO contract. The foundation chose, as the means for accomplishing these goals, a maximum of preadmission and concurrent admission review for both medical necessity and quality coupled with the minimum required retrospective review for admissions and other types of retrospective review. The primary retrospective area of quality review was to be a study of admissions within seven (7) days to identify disquality care occuring during the first admission resulting in the premature discharge of the Medicare patient. The foundation's approach to prevent unnecessary admissions and disquality care is somewhat different from the HCFA approach and the PRO scope of work which depends very heavily on the retrospective denial of payment for unnecessary admissions and retrospective determinations concerning quality of care. While the foundation feels retrospective review has a role in quality of care, we feel our approach is preventive rather than punitive. Our relationship with both HCFA regional and central offices has been good in spite of the fact that our review system differs markedly from that of other PRO's. Our system has complicated the problem of supervision at both the regional and central office level and the foundation appreciates the fact that coordinating and supervising our efforts causes an additional workload for both the regional and central offices. These supervisory efforts have sometimes resulted in conflicting instructions and an emphasis on process rather than outcomes. In the presence of conflicting instructions, the decisions of the PRO should be accepted.

II. The HCFA and HSQB effort to get the program up and running is commendable, particularly considering the many problems to be overcome. The time pressure to implement the program has caused a need for increased timely communication with the PRO's. Future changes in the program should be made with input from the PRO's and have implementation dates that will allow PRO's time to plan and communicate these changes to hospitals and physicians. As HCFA is planning to decrease its response time to PRO contract modification request, this will be helpful in the planning process.

III. The foundation's regional quality assurance committees have been very active in the review of medical records during readmission studies for premature discharge. A limitation to our effort is a shortage of contract funds for quality review. Our two (2) year contract was over $600,000 less than the DHHS audit of accepted costs of our proposal and both quality and utilization review efforts had to be curtailed. Our 100% prepayment system consisting of maximum preadmission review supported by concurrent admission review has proved cost effective in controlling admissions (see enclosure A) and also provides excellent opportunities to correct potential disquality care—before it is given. During the review process, questionable care may be identified by the foundation's physician advisors who then resolve any problems with the attending physician. Serious problems are referred to our medical director for his action. Our concurrent review process has identified one physician who is currently under sanctioning process.

IV. The foundation has made two requests to HCFA for funding to extend its review into the skilled nursing facilities in order to determine the medical conditions of patients transferred to skilled nursing facilities and to determine if the skilled nursing facilities have the capability to provide quality skilled level care. This program would allow us to deter premature discharges and better assure quality care in both institution and take the first step towards longitudinal patient studies. While our first request was denied, our current request is still under consideration. The foundation has also requested grant funding to refine its internally developed quality performance index into a valid comparable measure of quality of care. This grant request request has been approved by HCFA research and demonstrations for two years but has not as yet received funding.

V. In summary, the foundation's approach to PRO activity emphasizes prevention of unnecessary and disquality care based on "up front" review rather than financial punishment based on retrospective review and denial of payment. Mr. Chairman, on behalf of the foundation's board of directors, thank you for inviting us to share these views concerning the PRO program. The physicians and staff of the foundation are committed to ensuring that medicare recipients and employees of our private employers receive necessary quality care in the most cost effective setting.

SPECIFIC OBSERVATIONS AND RECOMMENDATIONS

I. Observations and Recommendations on what is needed to assure quality of care and to protect Medicare patients from substandard care.

1. Observation: Patients are not able to judge the quality of hospital care they receive.

Recommendations: A. Recommend patients receive education on what constitutes disquality care at discharge from the hospital. The Foundation has noted during studies on readmissions due to substandard care that patients are sometimes discharged which do not meet generic discharge indicators such as abnormal temperature, uncontrolled bleeding, open surgical wounds with drainage, continued chest pain, and other conditions, recognizable by the patient which should be adequately addressed in the hospital prior to discharge.

B. Recommend of a measure of quality of care based on outcome studies of patients discharged from the hospital be developed. The Foundation has submitted to HCFA on two separate occasions a request for grant funds to develop its Quality Performance Index (QPI). The grant request has been approved on each occasion, however it has not yet been funded. Representatives of the Foundation to include its physician and Ph.D. co-investigators met with Dr. Krakauer at HCFA on Thursday, September 19, 1985, and it is anticipated that some funding will be forthcoming.

2. Observation: This PRO has observed patients being discharged without meeting discharge indicators.

Recommendations: A. That a hospital be required to conduct a formal review against discharge indicators prior to discharge of Medicare patients. PROs would monitor this form on all retrospective chart review. This PRO currently looks at all records reviewed retrospectively against discharge indicators to identify and correct disquality care.

B. That PROs be given authority to decide which admissions to deny in the case of a readmission due to premature discharge on the prior admissions. After retrospective review it may be more appropriate to deny the first admission.

3. Observation: Patients are discharged with unresolved complications which constitute disquality care.

Recommendations A. That PROs conduct retrospective quality review of all discharges with bill diagnoses indicating complications.

II. Problems and deficiencies in the Foundation program for quality assurance and how these problems and deficiencies may be overcome and corrected.

1. Observation: Preadmission/concurrent admission review provides for identification and correction of potential disquality care. All Medicare admissions in the State of Alabama are subject to either preadmission or concurrent admission review and certification prior to payment by the fiscal intermediary. This allows for physician advisor to attending physician contact and discussion prior to performing scheduled operations or when potential disquality care is observed during the concurrent admission review process.

Recommendation: A. That PROs be encouraged to conduct preadmission/concurrent review rather than retrospective admission reviews in order to prevent rather than to punish for disquality and unnecessary care.

2. Observation: Retrospective quality review is very labor intensive. During the process of funding for the Foundation's PRO Proposal, the Foundation was prepared to discuss and justify all of its contractual costs associated with its proposal. At no time during the negotiation process was the Foundation allowed to present the justification of its cost or the impact that failure to fund at the requested Foundation funding levels would have on the Foundation's PRO Proposal. The Foundation was given a contractual financial figure and told to in essence "take it or leave it". This "take it or leave it" figure was $642,529 under the DHHS audit accepted cost of the Foundation proposal. An additional $341,945 was listed by the audit as "adjudicated" for negotiations. Included in the "adjudicated" figures were scheduled pay raises and projected increase in other necessary costs during the two year period of the contract. The Foundation could have reasonably expected to obtain all of the costs listed for adjudication if a reasonable negotiation process had been used. Another result of the loss of approximately $1 million from the contract, was eleven (11) positions in our Quality Assurance Department not being funded.

Recommendation: A. That in future contract negotiations PROs be allowed to present to the HCFA decision making persons the justification for the cost of their proposals and that HCFA recognizing that under funding of proposals can only result in changes in the PROs ability to perform according to its proposal. In our view the current funding does not provide for adequate quality assurance activities. It is unreasonable for HCFA to expect the PRO to provide all aspects of its proposal when funding to provide the persons and necessary support has been eliminated.

III. Flaws and deficiencies in Federal Regulations governing the program's goals and structures of the PROs and how these flaws and deficiencies may be overcome and corrected.

1. Observation: The HCFA Request For Proposal for PROs was designed around retrospective review instead of concurrent review in order to allow fiscal intermediaries to be able to meet the requirements of the proposal. Physician to physician peer review is most effective in both preventing unnecessary utilization and preventing disquality care when it is performed prior to or during the patient's hospitalization. The Foundation's approach of preventing the unnecessary service or preventing the disquality care on a preadmission or a concurrent review time system is

preferential to the retrospective review system which prevents neither unnecessary nor disquality care, but attempts to apply punitive measures based on retrospective determinations of medically unnecessary care or disquality care.

Recommendation: A. That PROs be encouraged and rewarded for performing preadmission and concurrent admission review of both medically necessity and quality and that the use of retrospective review be limited to those areas where preadmission or concurrent admission review are not feasible.

2. Observation: Regulations and HCFA instructions to PROs have not been provided in a timely manner. Both regulations and instructions on implementation from HCFA have often contained implementation dates which were unrealistic.

Recommendations: A. That PROs be given the opportunity to provide input to future HCFA instructions prior to the time they are published.

B. That all instructions to the PRO contain realistic implementation dates in order to allow PROs to study, plan and provide hospitals with timely instructions and implementation dates.

IV. Flaws, deficiencies and inequities in the Foundation's contractual arrangements with Health Care Financing Administration and how these flaws, deficiencies and inequities may be overcome and corrected.

1. Observation: The Foundation has encountered long delays in obtaining responses to PRO recommended contract modifications.

Recommendation: A. That a reasonable time frame to respond to PRO requested contract modifications be established and that when the PRO's request is denied an opportunity to discuss and provide additional justification to the proposal be provided.

2. Observation: Numerous instructions have been issued to the PROs which have modified the PROs contractual Scope Of Work. Some of these contain arbitrary determinations that the instructions to not constitute an increase in the PRO's workload.

Recommendation: A. That PRO representatives be allowed to meet with HCFA on each set of instructions issued by HCFA to negotiate a cost or range of cost which would be considered reasonable for performing according to the new instructions.

V. Flaws and deficiencies in the PRO program as it relates to the continuum of care following hospital discharge and how these flaws and deficiencies may be overcome and corrected.

1. Observation: The current PRO program does not contain any mechanism to follow Medicare patients after they have left the hospital.

Recommendations: A. PROs be given level of care and quality review authority for care provided to Medicare patients in the skilled nursing facilities. Skilled nursing facilities are currently required to have internal utilization review programs which are paid for by the Medicare program. PROs should be given this review authority in order to assess the condition of patients coming from the hospital to the skilled nursing facility, assess the ability of the skilled nursing facility to provide skilled level of care, and assure that patients paid for by the Medicare program actually require skilled level of care. The Foundation has made two (2) proposals to HFCA to provide skilled nursing facility review. The latest proposal was submitted to the HCFA contracts office on September 12, 1985. The Foundation is hopeful its proposal will be accepted by HCFA.

B. PROs have a capability to provide longitudinal patient studies of care provided to the patient in the hospital, skilled nursing facility, outpatient surgical setting, and home health care. PROs should be mandated to obtain Part B payment information at no cost from the fiscal intermediary in order to identify patients which are not receiving quality care or who are receiving unneeded care.

VI. Problems and deficiencies in the Health Care Financing Administration's overall administration, evaluation of your organization's program policy procedure and practice, and how these problems and deficiencies may be overcome and corrected.

1. Observation: Review teams who visit the PRO often have very narrow interpretations of what the PRO should be doing. These inspection visits are often very process oriented and ignore the fact the PRO is achieving its desired outcomes.

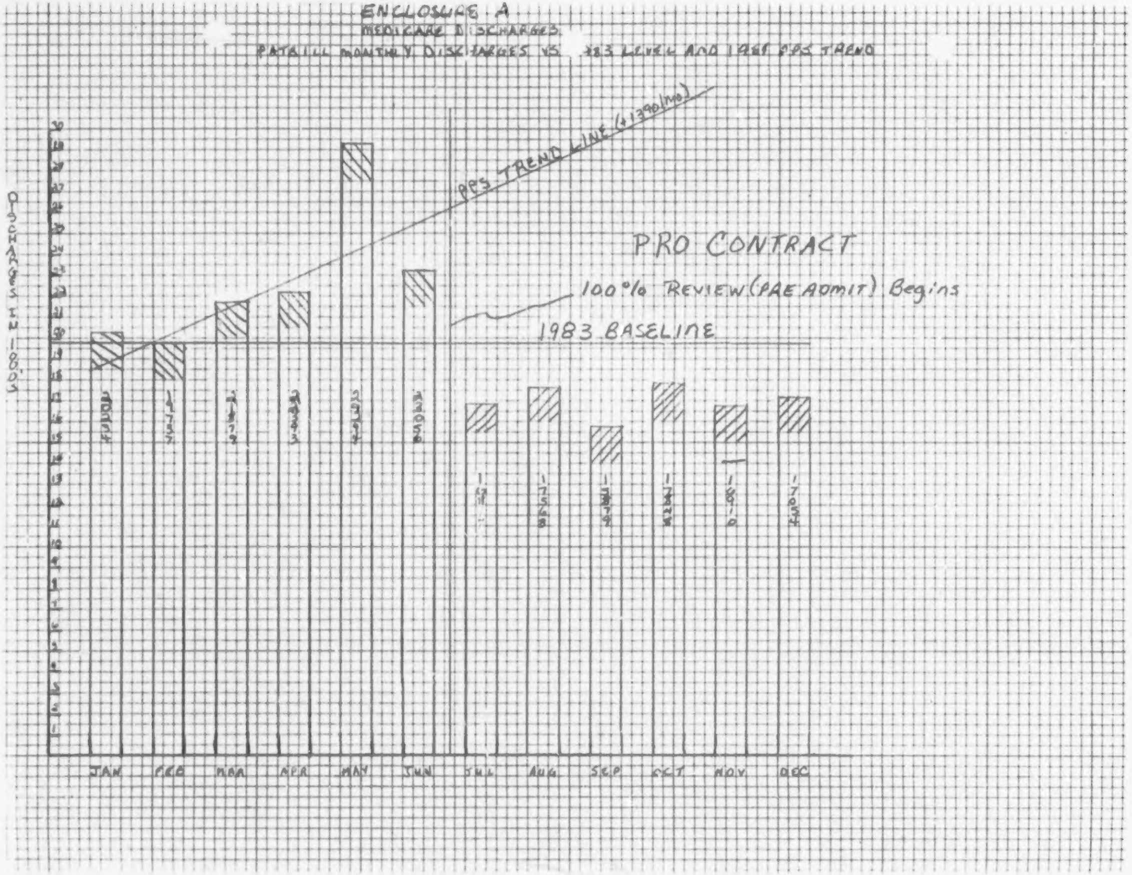
Recommendation: A. All HCFA Medical Review Teams receive standardized training in what they require of PRO and that visits become less process and more outcome oriented.

2. Observation: PROs have often received mixed signals from HCFA Central and Regional offices.

Recommendation: A. There be increased coordination and exchange of information between the HCFA Central and Regional Offices. Where shades of grey exist, differences of opinion should be resolved in favor of the PRO.

3. Observation: HCFA has collected quite a lot of information through the PRO program. To date very little of its analysis of this information has been made public or shared with the PROs.

Recommendation: A. Analysis of PRO data to include overall impact on utilization be provided to all interested parties.


ENCLOSURE A
MEDICARE DISCHARGES
PATBILL MONTHLY DISCHARGES VS 1983 LEVEL AND 1984 PPS TREND
PPS TREND LINE (+1390/MO)
PRO CONTRACT
100% REVIEW (PAE ADMIT) Begins
1983 BASELINE
DISCHARGES IN 1000's
JAN
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Chairman HEINZ. I just what to ask Dr. Platt the same question.

Dr. PLATT. Well, there are a couple of things I would like to just very quickly comment on. First of all, Senator, quality review is exceedingly more complex than utilization review. And you have to face the fact that if you are going to do it adequately, it is going to be more expensive on a case-by-case basis, or even on a broad spectrum basis, perhaps, than the utilization review.

No. 2, there is not, in our estimation, a great grouping of poorly cared-for patients out there that would fall through quality screening. Quality screenings properly applied will raise questions, but the number of poorly cared-for patients is really smaller, perhaps, than people basically believe.

For instance, we just did a summation of the last 75,000 admissions to Colorado hospitals under PRO, of which we reviewed one-third or 25,000—under the current system of review, now, understand, not using generic screens or quality screens. Out of that 75,000-plus, we turned up, using our current method of reviewing, about 119 cases of quality concern, which we have now under review. That is approximately 0.46 percent.

Chairman HEINZ. 0.46 percent?

Dr. PLATT. Right, of the review; 0.11 percent of the admissions.

So you are looking at a relatively small numerical number, based upon the current screens. Now, I have no question if we put in generic screens along with utilization screens, we would have more cases brought to our attention, and perhaps the percentages would go up.

But the return, the money spent for quality, which certainly should not be a quarrel between anybody, may not return to the Federal Government the dollar-for-dollar return that they are getting out of utilization review. And that is why they have always been reluctant to move into it.

I personally think now from the beneficiaries' viewpoint, and to a great degree from the practitioners' viewpoint, we should be moving in that direction, and more intently moving in that direction because of our concerns about the jeopardizing of quality under this type of system.

One question that has been constantly raised here is the problem of malpractice and the relationship to review. When you move from utilization review to quality review, you will intensify those malpractice concerns, because when you question a physician's performance under a quality screen, you increase the exposure to the malpractice concern. So when we move from utilization into quality, to the physician community and to the provider community, the concern about our activity will go up geometrically because of that relationship between quality screening and malpractice.

I merely bring that up because it has been an undercurrent of Senator Warner's concerns, and some of the doctors on the previous panels, and it is legitimate.

Chairman HEINZ. I thank you for bringing that up.

Let me ask—and this, I think maybe you can answer largely with a "Yes" or "No." We heard from the first panel, the three women whose mothers had very tragic experiences and, to my mind, received medical treatment that seriously went awry. Are you able to identify such cases that result in a patient's death? Is there any way of tracking available? Yes or no—Dr. Sherrill?

Dr. SHERRILL. Well, our board has been very concerned with this exact problem. What happens to the patient we deny? So we have been attempting to track that. Not having the capability or the legal authority to go beyond the hospital, the only way we have to track it is to look at are these patients being readmitted to the hospitals.

Chairman HEINZ. You are trying to do that on your own?

Dr. SHERRILL. That is right

Chairman HEINZ. This is not something you are asked to do or are paid to do?

Dr. SHERRILL. No.

Chairman HEINZ. Dr. Crisafulli.

Dr. CRISAFULLI. There is no way we can track these patients at the present time.

Chairman HEINZ. Dr. Dehn.

Dr. DEHN. Untoward events that occur outside the acute care facility, we cannot track.

Chairman HEINZ. So once someone is discharged and something bad happens to them, unless they are readmitted within 7 days——

Dr. DEHN. Senator, it goes beyond that.

Chairman HEINZ. Nobody knows what is happening to them——

Dr. DEHN. That is correct.

Chairman HEINZ. And nobody can really judge whether they have been prematurely discharged.

Dr. DEHN. That is correct. But there is a corollary issue, and I will be very brief. It is not only after discharge, Senator, but all the incentives in the system are to deliver more care on an outpatient basis—that is to say that there is more ambulatory surgery being done outside of the usual definition of an acute care setting So it is not only after discharge that we are losing track of health care delivery, but it is even before admission.

Chairman HEINZ. Dr. Platt.

Dr. PLATT. Well, from Colorado's viewpoint, the answer is yes—but only because we have a contract with the State Department of Social Services to do long term care review. In those three cases you heard this morning, that was a transfer hospital-to-nursing home. We would have been aware of those cases immediately, but only because we are involved in the continuum of care beyond the hospital.

Chairman HEINZ. But you would not report that to HCFA. You might report it to the State.

Dr. PLATT. Well, if it is under the Medicaid Program, it would be reported to the State, that is correct.

Chairman HEINZ. But it would not show up down at the Health Care Financing Administration as part of their review of DRG's, because DRG's are Medicare, not Medicaid.

Dr. PLATT. It would if, because of that encounter in the nursing home, we decided that happened because of a premature discharge; then it would become a premature discharge under the Medicare Program.

Chairman HEINZ. It would. You are somewhat unique in that regard.

Yes.

Mr. LYNCH. Senator Heinz, you have, in my opinion, touched upon a very, very important problem regarding the health care system, and it is this: It is fragmented, and the left hand does not know what the right is doing. In terms of that question you just asked Dr. Platt, it clearly reflects the concept of what is needed in the United States is not just a concern with Medicare, but what is happening with other types of payors and the quality of care being delivered for those populations. We do not have the answers. We do not have the data. We do not have the review.

In Rhode Island, which is an extremely small State—I believe it is smaller than Pennsylvania—we have a delegated system, as far as I can see, for other payors. Our review is external to the hospital, which really avoids conflicts of interest. And in terms of continuity of care for the Medicare Program, as Dr. Platt has said, I think it is crucial. In Rhode Island, we tried to establish a bed registry to link up the acute care hospitals with the nursing homes. And in fact, in my judgment—I do not want to be accused of talking too much——

Chairman HEINZ. That is usually reserved for Senators.

Dr. PLATT. But not from Rhode Island. [Laughter.]

Mr. LYNCH. Senator, I will pass that along to Senator Chafee.

Chairman HEINZ. I am staying out of that argument:

Mr. LYNCH. To sum up, basically, we not only have a fragmented system, a system bastardized, if you will, with the Medicare Program, but across-the-board.

Chairman HEINZ. I want to get your reaction to some of the recommendations that are part of the staff report on the DRG process. There are a total of 10 recommendations prepared by the staff, all aimed at improving quality of care. There are five of them I would like to address your attention to, and I am going to read them out one at a time and then ask for a very brief comment.

Recommendation No. 1 is that Congress should enact a set of adjustments to DRG classification similar to those developed at Johns Hopkins to better reflect differences in the severity of illness between patients in each DRG category.

Dr. SHERRILL. I certainly agree.

Dr. CRISAFULLI. Absolutely.

Dr. DEHN. Absolutely.

Dr. PLATT. Absolutely.

Mr. LYNCH. Absolutely.

Chairman HEINZ. Unanimity. That is hard to get in this day and age.

Recommendation No. 3, the Secretary should revise the PRO scope of work now being drafted by HCFA for the second round of PRO contracts to require comprehensive quality assurance monitoring and enforcement activities.

Dr. SHERRILL. Are we talking about longitudinal follow-up on the patient?

Chairman HEINZ. Yes, we are.

Dr. SHERRILL. We are in favor.

Chairman HEINZ. Dr. Crisafulli?

Dr. CRISAFULLI. Yes, I agree.

Dr. DEHN. "Comprehensive" means ambulatory care and aftercare; absolutely.

Chairman HEINZ. Yes, that is correct.

Dr. Platt.

Dr. PLATT. I agree.

Chairman HEINZ. Rhode Island gets two bites at the apple.

Mr. LYNCH. I agree.

Dr. CRISAFULLI. We represent two States, Senator.

Chairman HEINZ. Yes, that is right. All right.

Recommendation No. 4, Congress will—if we are going to do it—Congress should pass S. 1623, introduced by myself, which is incorporated at least in the Senate's reconciliation package, which for the first time authorized PRO's to deny reimbursement for substandard care provided to beneficiaries under Medicare while helping guarantee the financial viability of the PRO's.

I am not certain if the House reconciliation package has all of those, but this is of immediate interest and concern.

Dr. Sherrill.

Chairman HEINZ. Dr. Crisafulli?

Dr. CRISAFULLI. I agree, but not as the only way of dealing with substandard care.

Chairman HEINZ. Oh, I think we are in agreement on that. This is just a start.

Yes.

Mr. MILLER. I would like to put a comment on that, also, and that is that the PRO's are given the flexibility to decide whose payment is going to be denied and not be directed that we have got to do first or second——

Chairman HEINZ. Yes, that is a well-taken point. I thank you.

Dr. Dehn.

Dr. DEHN. Senator, right now, the only thing that a PRO can use to penalize for quality concerns is a sanction, and that seems like a thermonuclear weapon, and what you are suggesting here is the opportunity to use some conventional weapons, and we are in support of that.

Chairman HEINZ. Dr. Platt?

Dr. PLATT. Yes, I would agree, but with just a very continued plea for flexibility, particularly in this area.

Chairman HEINZ. I hear you.

Mr. LYNCH. I can add nothing, Senator.

Chairman HEINZ. Recommendation No. 8, PRO's responsibilities for quality assurance should be extended so that they are required to track a pre-specified percentage of patients discharged from the hospital through the continuum of nursing home, home health care, and other community-based services. In a sense, we have already touched on that, and I think the answer is the same as to the earlier one.

Recommendation No. 10, Congress should authorize the creation of an interagency panel consisting of representatives of Congress, HCFA, PROPAC, AFRA, and the Office of the Inspector General, beneficiaries as well as health care practitioners and provider representatives, the purpose being to make a concerned effort to seek out quality problems in hospital, as well as post-hospital, and to develop criteria for a uniform quality of care review system. The idea would be that such a panel would report to Congress first, as soon as practicable, and I presume periodically thereafter.

Dr. Sherrill.

Dr. **Sherrill**. I have not ever seen this before. I do not know how many levels we need to look at this. It would seem to me that the PRO's are supposed to be given the responsibility for looking at the quality of care, and that they should with the right amount of flexibility, be able to address the situation.

Chairman **Heinz**. What we are trying to do is not create a new level, we hope, but coordinate existing levels.

Dr. **Sherrill**. I would have no problem with that.

Chairman **Heinz**. Dr. Crisafulli.

Dr. **Crisafulli**. I would agree with it, provided that the concept of "uniform" refers to the review process, and not necessarily to the quality of care. There is a very serious concern about "cookbook" medicine which I do not think we should be getting into.

Chairman **Heinz**. The answer to the inquiry is "Yes"; the point is nonetheless well-taken.

Dr. **Dehn**. Absolutely. It mandates dialog between the providers and the Health Care Financing Administration.

Chairman **Heinz**. I gather you feel there is not very much going on right now?

Dr. **Dehn**. It is a little thin, a little thin right now.

Chairman **Heinz**. Dr. Platt.

Dr. **Platt**. I have no objection, with a certain caveat. Under the PSRO program on the National Council level, we had great concerns about uniform national standards or criteria. In Tennessee, when you put together a commission of a grouping as prominent as this, to come up with guidelines for quality, for that would be relatively easily transformed into national quality guidelines or standards, as long as there is, under that type of approach, flexibility at the local PRO level, so that they are not mandated to follow exactly a national criteria set, I would agree with them.

Chairman **Heinz**. Before I call on Senator Cohen, I just want to make a brief summation of what you and our other panelists have testified to today, at least in my judgment, and I suppose you are free to agree or disagree. But I think the first thing we have found, and it has been particularly emphasized and underlined by you, is that the Health Care Financing Administration figures on premature discharges are utterly unreliable. There is no way that they can gather that information. And hence, they necessarily are ignoring the true extent of many kinds of quality of care problems that are afflicting Medicare beneficiaries, as we have seen from the first panel, with extraordinary adversity, and that is happening because PRO contracts, your contracts, do not provide for either the funding of the instructions to comprehensively review quality problems. And I see that each of you at the witness table are nodding in the affirmative. Second, it seems that DRG's do a poor job of accounting for the cost of caring for severely ill patients, creating financial pressures on hospitals and, in turn, on th physicians to shortchange patients on treatment; and, as we have just discussed, you seem to be in agreement that DRG's—and this was true of the physician panel, previously—that DRG's could be adjusted for severity of illness to mitigate that problem.

Third, hospitals indeed are pressuring doctors, who in turn pressure patients, to accept inappropriate treatment. I see some of you at the witness table nodding in the affirmative.

Fourth, seriously ill Medicare patients are both inappropriately barred from admission—and here, I think there is some disagreement between you and some of the doctors—and discharged from the hospital, which you do not have much disagreement about.

Fifth, patients and families are still being given false and incomplete information regarding their right to appeal a proposed discharge.

Now, maybe in one of your States, you are doing a superb job, but everything we have seen, the beneficiaries have absolutely no idea that they have the right to appeal.

I see Dr. Sherrill wants to make a comment at this point.

Dr. **Sherrill**. I just want to say that I think education is one of the most important elements that we need to address, along with the flexibility, and I do not think the physicians, in many cases, have all the information, or the hospitals, or certainly the beneficiaries.

Chairman **Heinz**. And one other finding is that the number of patients being discharged out of hospitals in need of care, particularly as evidenced by the experience of Ms. Jones in North Carolina, where the number of people needing home health care in virtually every one of the four categories that she enumerated, have doubled or more than doubled. This suggests that the problem is not just growing, but already huge. And I see everybody at the witness table agreeing with that.

Let me introduce probably the most active member of this committee, who has worked on the problems of the aging back in the House, when he and I were working on the problems of the aging together, and that takes us back a long way.

Senator Cohen, of Maine.

STATEMENT BY SENATOR WILLIAM S. COHEN

Senator **Cohen**. We have aged considerably since that time, both of us, Mr. Chairman.

Mr. Chairman, thank you, and I do apologize to the panel here and to those that preceded you, that I could not be here earlier. I had to attend three other committee hearings this morning, all of which tend to meet at the same time. So I do apologize.

But I commend the Chairman for holding this hearing, the first in a series of hearings dealing with this issue. I think we are always going to be confronted with the essential tension and conflict between cost and quality of care. As the pressure continues to mount for increased cost controls, it is going to put us in tremendous tension with quality of care requirements.

I think it is important to our cost containment efforts that every admission be appropriate. But, in my judgment, it is even more important that, in our efforts to maintain quality care, that we take steps to insure that every discharge be appropriate. That is the problem that we are attempting to address today, the appropriateness of the discharge. And I think even though the statistical information is incomplete, it is clear that people are being discharged earlier because of financial considerations mandated by Congressional action.

My problem in Maine is not so much that patients are being discharged from hospitals sooner. In fact, there are many elderly people who do not object to being discharged early. They do not like hospitals, frankly, and would like to get out as soon as possible. The difficulty is they often have no place else to go. Often they live in rural areas, and there is no skilled nursing facility available. They have no alternative but to go home, where the level of care available may be entirely insufficient to their needs.

These patients have been, in effect, delegated to a so-called "no care zone."

With respect to your suggestion about education, I am happy to say that my constituents in Maine have taken positive action and created a task force composed of representatives of a number of groups, primarily the Maine Committee on Aging, the Maine Hospital Association, and the Maine PRO. They are working together to inform beneficiaries of their rights under this new system. I think that we need more of this kind of cooperation effort in other States, as well.

Mr. Chairman, I would like to insert my statement for the record. I apologize for coming in at the very end of your presentation, and I hope to be able to attend the future meetings.

Chairman HEINZ. Senator Cohen, without objection, your entire statement will be made a part of the record.

[The prepared statement of Senator Cohen follows:]

PREPARED STATEMENT OF SENATOR WILLIAM S. COHEN

Mr. Chairman, I want to commend you for calling this hearing today to examine the extent to which the quality of health care available to our nation's elderly may have deteriorated under the new Medicare prospective payment system.

Such an investigation is both timely and necessary. All of us have read—or heard from our constituents—accounts of hospitals discharging medically unstable Medicare patients prematurely. However, until now, evidence of this practice has been largely anecdotal and the true scope of the quality of care problem unknown.

The Medicare prospective payment system does appear to be meeting its primary objectives of increasing hospital efficiency and containing hospital costs. Health care spending in the United States increased by only 9.1 percent in 1984, the first time since 1965 that the growth rate has dropped below double digits. Hospital utilization is also down. Data from the American Hospital Association show that admissions to community hospitals dropped 3.7 percent and the number of inpatient hospital days fell 8.6 percent in 1984.

Certainly, I support and applaud these efforts to contain health care costs. However, I believe that we have an even more important obligation to ensure that the quality of care available to Medicare beneficiaries does not deteriorate under this new system. While it may be important to our cost containment efforts to ensure that each hospital admission is "appropriate," it is even more important that we take the steps necessary to ensure that each hospital discharge is equally "appropriate."

Given that shorter hospital stays are likely to remain a reality dictated by financial necessity, we must also take steps to eliminate what has been called the "no-care zone." The problem in Maine is not so much that we are discharging patients earlier. In fact, most elderly patients would prefer to get out of the hospital as soon as possible. The problem is that we don't have the "continuum of care" necessary to provide for the needs of those being discharged from the hospital "sicker, quicker." While a patient might not need the acute level of care provided in a hospital, there are not always sufficient services outside the hospital—specifically skilled nursing facilities and home health services—available to help that patient bridge the gap between sickness and health.

Finally, it also seems clear that we need to increase our efforts to educate Medicare beneficiaries about the new system and its potential impact on their care. In Maine a special task force, comprised primarily of representatives from the Maine Committee on Aging, the Maine Hospital Association, and the Maine PRO, has been formed to help inform Medicare beneficiaries of their rights under the new system. This task force is currently working on a brochure which clearly outlines the Medicare payment system and the appeals process available to the patient should he feel that he is being discharged prematurely. I would like to take this opportunity to commend this Maine task force for its efforts and to encourage similar undertakings elsewhere.

Chairman HEINZ. Let me just say that Senator Cohen has had an abiding interest in what we often call "the continuum of care" interest. And I remember back in 1977 and 1978 and 1979, when Senator Cohen was taking the lead, along with Senator Chiles, then the chairman of this committee, trying to get the then Carter administration to simply provide some options on how we could address the so-called long-term care issue in this country. We are still waiting for the Department of Health and Human Services to come forward with their recommendations, which were mandated by law sometime back in 1977. Senator Cohen, I believe, was the author of that particular provision, a good example of his depth of involvement in this issue. Yes, Dr. Sherrill.

Dr. SHERRILL. Senator Heinz, I just wanted to make one remark in reference to Dr. Cohen—Senator Cohen's——

Senator COHEN. "Doctor" is fine.

Dr. SHERRILL [continuing]. You are elevated or decreased, I do not know which. In reference to the long-term care situation. Many places do not have the acute care or nursing home skilled care levels, or even enough nursing homes to do the job. And it has been brought out, as we get a decrease in the inpatient hospitalization, possibly a wing or some of these beds can be used as a shift in care. The problem that we have with that, I think—and a lot of hospitals will attest to this—is that if they ask for these beds to be shifted to skilled level nursing care beds, then they lose those beds as acute beds, and the law will not allow them to get them back as acute beds, and they are afraid to give them up for this purpose. If there were more flexibility here in the law that would allow them to regain those beds if, down the road, they see that they are needed as acute care, then they could get this—there would probably more more attempt at utilizing these beds in that capacity.

Chairman HEINZ. Do you have a comment, Dr. Platt?

Dr. PLATT. Yes. You know, as a senior statesman sitting on this panel, having gone through this now for 15 years, and helping Bennett write that amendment that got us into all this jeopardy, I would just like to make one sort of gratuitous comment to perhaps give you my perspective after 15 years of where we are heading.

Under PSRO, we went through the monitoring type of approach to peer review. We are now, under PRO, in what I call the enforcement type of peer review where we enforce the system. But the ultimate role of a peer review agency, when you move into quality review, may become not the monitors or the enforcer, but the patient's advocate.

We could be put in a position under quality review where, if we begin to perceive that whatever program the Federal Government or the State governments or the private insurers are doing are pushing us into a position where we are jeopardizing the quality of care, becoming a public patient advocate.

I mentioned that before one of our State legislators, and he became rather incensed at the concept, because he felt it was unethical for me to take State money to provide a data base upon which I might attack the State agency that provided the money where I got the data base. I told him what I will tell you gentlemen, and I am sure you are aware of this, that my ultimate constituency is not the U. S. Senate or the House of Representatives, or HCFA or the State or the third-party payor; it is my patient. And we may find ourselves in an adversarial role, unnecessarily, perhaps, but practically, if we find quality of care is being jeopardized.

Senator WILSON. Mr. Chairman, I can only say I think that is a statement to be applauded, and I do not think it is to be deplored in any way. Until such time as a physician renounces his hippocratic oath, it seems to me that is clearly your first responsibility, and I think that while we are in the unenviable position of having to reconcile a complex set of considerations, that that is our first concern, as well. We have got to do all that can be done about holding down the costs of health care, but I think peer review should be understood to have that role now. In fact, the only thing that troubles me about your statement is saying that we may be getting there.

Chairman HEINZ. Senator Wilson, that is a well-taken point. I want to just note that this is the third trip back here that Senator Wilson has made this morning, the mark of a conscientious Senator.

Some people actually felt sorry for Senator Wilson when he had to come to the Senate floor to vote on the budget.

Senator WILSON. I did.

Chairman HEINZ. All the people who felt sorry about that traumatic trip were not politicians.

Senator Wilson did feel sorry, I would note for the record.

I want to express the deep appreciation of the committee to all of you, who have come so far on behalf of the PRO organizations, for making a major contribution to this committee. You have dispelled a tremendous amount of the conventional "inside-the-beltway" wisdom, that everything is all right outside the beltway. And you are uniquely qualified to speak for large numbers of people, large numbers of providers, large numbers of beneficiaries. And while some people might wrongly, I feel, dismiss our first panel of witnesses as merely three examples of anecdotal case histories, and that it represents a nonprojectable kind of sample, nonetheless, what you have testified to today is that there is an appalling lack of information and knowledge as to what is taking place, and there is no evidence to show that the kinds of cases that we have heard today are in any way merely anecdotal or in any way somehow unique or extraordinary. We would like to believe that they are, but there is no evidence one way or the other to suggest that they are not. And we need to be sure that we get our DRG quality assurance act together just as quickly as possible. Otherwise, we will be doing the medical profession a disservice, we will be doing you a disservice, we will be doing the Congress and the administration a disservice, for failing in a job in which we do not need to fail; and finally, and most importantly, we will be mal-serving the senior citizens who have aid into the Medicare Program in the expectation of receiving a reasonable level of quality of care—the largest disservice of all. And that, I believe would be unthinkable.

I want to thank everybody for their participation, and unless there is further comment, the hearing is adjourned.

[Whereupon, at 12:10 p. m., the committee was adjourned.]

MEDICARE DRG'S: CHALLENGES FOR POST-HOSPITAL CARE

THURSDAY, OCTOBER 24, 1985

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The committee met, pursuant to notice, at 9:30 a.m., in room SD-628, Dirksen Senate Office Building, Hon. John Heinz (chairman), presiding.

Present: Senators Heinz, Glenn, Chiles, Burdick, Pressler, and Grassley.

Staff present: Stephen R. McConnell, staff director; Robin Kropf, chief clerk; James F. Michie, chief investigator; David Schulke, investigator; Lucia DiVenere, professional staff; Diane Lifsey, minority staff director; William Benson, minority professional staff; Kimberly Kasberg, staff assistant; Diane Linskey, staff assistant; Ann Williams, office manager; Steve Folsom, staff assistant; and Dan Tuite, printing assistant.

OPENING STATEMENT BY SENATOR JOHN HEINZ, CHAIRMAN

Chairman HEINZ. Ladies and gentlemen, good morning. This hearing of the Special Committee on Aging will come to order.

Just 4 weeks ago, this committee convened to hear testimony on the impact of the administration's new Medicare cost containment program, diagnosis-related groups, or DRG's, on the quality of hospital care afforded 30 million older Americans. Witness after witness documented the findings of the committee's own 4-month investigation: without major reforms, Congress can offer little assurance that quality hospital care and Medicare are not mutually exclusive concepts. At this point I would like to insert in the record the full report of the committee's investigation.[1]

Hospitals denying admission to what they consider DRG losers and creating winners through premature discharge; pressure on doctors to violate their own medical judgment in treating patients; a hamstrung enforcement power—this was the bad news from the September 26 hearing.

But the worst news was that abuses for profit do not stop at the hospital discharge door. Tragically, thousands of older patients still in need of heavy medical assistance feel the cost squeeze in the community as well.

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[1] See p. 314.

In April, the Health Care Financing Administration reported to Congress that DRG's create no significant effect on hospital discharges and by implication have not affected the ability of nursing homes, home health agencies and families to continue care in the community. They based these so-called truths on a so-called nationwide survey of 21 home health agencies, having scrapped a second study of nursing homes.

The Health Care Financing Administration's official accounting on Capitol Hill differs dramatically from data prepared for the agency's Administrator. Shown on the chart to my right is the Health Care Financing Administration's internal assessment, which clearly demonstrates substantial increases in discharges of very sick patients to skilled nursing homes and home health care. In fact, since DRG's went into effect in October 1983, discharges to skilled nursing homes and home health care agencies have increased by almost 40 and 37 percent, respectively. In conservative numbers, this represents tens of thousands of additional patients ushered from hospitals who still require heavy care.

Repeatedly over the past months, this committee has asked the administration's help in resolving conflicting reports of DRG abuses. Repeatedly over the past months they have misrepresented or withheld evidence of problems and abuses, presuming ignorance can replace truth. We must deal with the truth as we find it, therefore. And when it comes to the quality of care in the community, the truth we find, unfortunately, is far from rosy.

Now, as we are going to hear today, problems begin with discharge planning in the hospital. DRG's encourage pinball discharges, with patients propelled haphazardly to nursing homes, rehabilitation centers, or families. Many nursing homes, up against a budget-conscious administration and the very real threat of reimbursement denials, turn away all but the sure bet patients. Other facilities simply cannot provide the level of care required by sicker patients. Home health agencies report patients sent home with inadequate discharge planning, often in need of services the agency cannot provide, or for which Medicare would deny coverage.

Today this committee is releasing a report entitled "Medicare's Prospective Payment System: Strategies for Evaluating Cost, Quality and Medical Technology." [1] This report has been prepared by the Office of Technology Assessment on Medicare's Prospective Payment System. And the report emphasizes very strongly indeed the need for a substantial increase in monitoring and the study of impact from the prospective payment system, the DRG's that I have described.

The report states, and I quote, "the amount of funding currently available for an evaluation of prospective payment within the Health Care Financing Administration is inadequate. Budget cuts would exacerbate the problem."

Most significantly for our hearing today, the report notes that while peer review organizations, PRO's, are responsible for protecting against certain extreme effects of DRG's on inpatient care, their responsibility stops at the hospital door.

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[1] Report is retained in committee files.

One of the recommendations contained in the committee's staff report is to authorize and fund peer review organizations, the watchdogs that Congress set up in 1983, to authorize and fund those peer review organizations to expand their reviews to include nursing homes and home health agencies.

It is my view, and I hope it is shared by the members of this committee, that Congress must take every appropriate action to assure Medicare beneficiaries the high quality of health care they have paid for and which they anticipate.

I am convinced that we can effectively save the taxpayers money and cut costs as needed, while protecting patients, as I believe Congress intended and has promised.

We have a very full schedule of witnesses today, and I look forward to their comments, but before we turn to them, I want to introduce the ranking member of this committee, Senator Glenn, who has worked so closely with us in this review of DRG's.

Senator Glenn, I am delighted you are here, and I am sure you have some comments.

STATEMENT BY SENATOR JOHN GLENN

Senator GLENN. Thank you, Mr. Chairman. I do, indeed. As ranking member on this committee, I am pleased to join you in today's hearing to examine the appropriateness, the availability, and the quality of services for Medicare beneficiaries, following their discharge from the hospital.

This hearing today is to follow up on our September 26 hearing, where we heard poignant and disturbing testimony about the impact of Medicare's prospective payment system, or PPS, based on diagnosis-related groups, or DRG's, on many beneficiaries, in terms of quality and access to care in the hospital setting.

We are here today to talk about the impact that the so-called diagnosis-related groups have on Medicare beneficiaries after they are discharged from the hospital. And what we will hear is frightening. We will learn that elderly patients are being sent home with serious illnesses that require ongoing medical care. They are being sent home with implanted catheters, with spinal column injuries, and with tracheotomies. In some cases, they are dependent on oxygen or need intravenous therapy, and in other cases, they must be fed through tubes, or are in need of extensive physical therapy. But they are all sick—very sick—and they all require professional care. And, they are too often not getting it.

Thanks to the Reagan administration, right now Medicare coverage is often denied to those who need home health care and other kinds of health care that does not occur in a hospital by the fiscal intermediaries, who have been directed to cut back on expenditures. Moreover, the administration recently announced that next January, Medicare beneficiaries can expect a 23-percent jump in their hospital deductible, from $400 to almost $500 per stay; and in the skilled nursing home payment, from $50 to $61.50 daily. Now, that is a big additional financial burden for the sickest of Medicare beneficiaries. As a result, thousands of older Americans are not getting any care at all and as we shall hear, the results can indeed be tragic.

That is why I especially want to thank our two Ohio witnesses today—Mrs. Marie Bell and the Reverend Roland Hornbostel, of Cleveland. I am sure your testimony will help heighten public awareness of these problems, and your speaking out will go a long way toward helping to solve them. We appreciate your being here.

I have become increasingly disturbed, indeed angered, by administration efforts to cut essential services for Medicare beneficiaries once they are discharged from the hospital. The administration appears to be making every effort to reduce home health services and skilled nursing benefits under the Medicare Program at the very time when they are needed more than ever before.

I have a longer written statement which I would ask be entered into the record, Mr. Chairman, which gives many examples, such as their definition of intermittent care, changes in reimbursement metholodogies for home health benefits, and proposed changes in the waiver of liability for home health agencies and skilled nursing facilities. Also, in the longer written statement, I discuss the effect on Medicaid, which pays some 90 percent of the public nursing home bill in our country, and the effect on Medicaid patients of the lack of public and private reimbursement for posthospital care. I also discuss the impact of increased discharges of Medicare patients to skilled nursing homes on bed availability for Medicare patients.

My home State of Ohio has enacted legislation with regard to reimbursement for Medicaid patients in nursing homes, and against discrimination toward Medicaid patients. These laws may be models for dealing with some of the issues we are now discussing.

Today's witnesses include two ombudsmen and the wife of a Medicare beneficiary who was helped by an ombudsman. The work of ombudsmen and other advocates for the elderly is crucial to assisting our most vulnerable citizens to find their way through bureaucratic mazes and to assert their rights to appeal decisions by Medicare and other programs that adversely affect them. This committee is concerned about the administration's support for the ombudsman program. It clearly needs to be strengthened and made more widely available.

There is much that needs to be done to protect the rights of Medicare and Medicaid beneficiaries and to ensure that quality care is provided as Congress intends. A few of those actions that we intend to pursue include strengthening the appeal rights, informing the beneficiaries of their rights, improving discharge planning in hospitals, examining the current classifications of nursing home care under Medicaid and making changes that reflect the actual needs of residents, and improving Federal requirements for protecting nursing home residents.

So, Mr. Chairman, I look forward to joining you and other members of this committee in pursuing legislation or administrative changes that may be needed on behalf of these very vulnerable elderly.

I appreciate the participation of today's witnesses, who have come long distances, and I look forward to their testimony. And, as you mentioned, we are glad to be releasing today this study that was done by the Office of Technology Assessment, entitled "Medicare's Prospective Payment System: Strategies for Evaluating Cost, Quality and Medical Technology." The report should add a great deal to our knowledge about the overall impact of DRG's on our health care system.

Thank you.

Chairman HEINZ. Senator Glenn, I thank you for your excellent statement. Without objection, the entire statement will be made a part of the record, and I want to thank you personally for both you and your staff's assistance in not only helping us identify such good witnesses, and really significant case histories, as Mrs. Marie Bell, but in many other ways as well.

[The prepared statement of Senator Glenn follows:]

PREPARED STATEMENT OF SENATOR JOHN GLENN

Mr. Chairman, as the ranking democratic member of the Senate Special Committee on Aging, I am pleasedl to join you in today's hearing to examine the appropriateness, availability and quality of services for Medicare beneficiaries following their discharge from a hospital. This hearing is necessary to follow up on our September 26 hearing where we heard poignant and disturbing testimony about the impact of Medicare's Prospective Payment System [PPS], based on Diagnosis Related Groups [DRG's], on many beneficiaries, in terms of quality and access to care in the hospital setting.

That hearing brought us here today, to learn about the impact of the DRGs on Medicare beneficiaries after they have been discharged from the hospital. We will hear disturbing testimony from today's witnesses about serious problems faced by many elderly citizens who have relied upon Medicare to meet their health care needs after they leave the hospital. These problems include difficulties in obtaining services that are appropriate and necessary for the needs of the post-hospital patient, and in obtaining Medicare reimbursement for needed services. As the first hearing demonstrated, and today's testimony will underscore, Medicare patients are leaving hospitals still in need of serious medical care and attention. Some beneficiaries are being released to settings that cannot meet their needs, either because Medicare reimbursement is being denied or is inadequate for such services. In other cases, the appropriate care is just not available.

We are here today to talk about the impact that the so-called Diagnosis Related Groups have on Medicare beneficiaries after they are discharged from the hospital. And what we will hear is frightening. We will learn that elderly patients are being sent home with serious illnesses that require on-going medical care. They are being sent home with implanted catheters; with spinal column injuries; and with tracheotomies. In some cases, they are dependent on oxygen or need intravenous therapy. In other cases, they must be fed through tubes or are in need of extensive physical therapy. But they are all sick. They all require professional care, and they are too often not getting it.

Thanks to the Reagan Administration, right now Medicare coverage is often denied to those who need home health care—or need many other kinds of health care that don't occur in a hospital. Moreover, the Administration recently announced that next January, Medicare beneficiaries can expect a 23 percent jump in their hospital deductible—from $400 to almost $500 per stay—and in the skilled nursing copayment—from $50.00 to $61.50 daily. This is a huge additional financial burden for the sickest of Medicare beneficiaries. As a result, thousands of older Americans aren't getting any care at all—and as we shall hear, the results can be tragic.

And that's why I especially want to thank our two Ohio witnesses today—Mrs. Marie Bell and Rev. Roland Hornbostel of Cleveland. Your testimony will help heighten public awareness of these problems. And your speaking out will go a long way toward helping us solve them.

I have become increasingly disturbed, indeed angered, by Administration efforts to cut essential services for Medicare beneficiaries once they are discharged from the hospital. As I mentioned, the Administration appears to be making every effort to reduce home health services and skilled nursing benefits under the Medicare program at a time when they are needed more than ever before.

The regulations governing home health care are inadequate. In the absence of adequate regulations, the Administration issues directives, sometimes orally, to the final intermediaries that pressure them into making Medicare coverage more difficult for beneficiaries to obtain. One glaring example is the Administration's 1983 definition of "intermittent care" for home health coverage that has resulted in many Medicare denials. Senator Heinz and I have introduced legislation—S. 778, the "Home Care Protection Act of 1985"—to ensure that Congressional intent for a fair and consistent standard allowing up to 60 days of daily home health visits, with physician certification, is followed by the Administration.

In May of this year, the Administration proposed a new methodology for reimbursement of Medicare home health services to take effect on July 1, that will likely result in many home health agencies closing their doors. Members of this Committee joined together in introducing legislation—S. 1450—to stop the implementation of this new scheme. We are hopeful that Congress' budget reconciliation effort will block the Administration's attempt to impose this major change. Reduced home health services, as well as skilled nursing care, for Medicare beneficiaries would be the outcome of the Administration's move to eliminate the "waiver of liability" for these benefits. The waiver of liability allows the home health agency and the skilled nursing home a small margin of error (2.5% and 5% of claims respectively) in accepting patients for whom the fiscal intermediary may later deny Medicare coverage. Even though the change in the waiver is currently on hold, fiscal intermediary pressure on home health agencies and nursing homes is resulting in patients facing huge out-of-pocket costs or being denied desperately-needed services.

Skilled nursing homes are seeing patients in much greater numbers who requires intensive and extensive medical care, thus straining the resources of these facilities in their attempts to provide these needed services. The lack of public or private reimburement for post-hospital care, as well as current demographic trends, are seriously affecting Medicaid, the federal and state programs which pays some 90% of the public nursing home bill in our country. The Medicaid reimbursement structure appears to be becoming quickly outmoded and irrelevant in light of these pressures. My home state of Ohio has implemented a new reimbursement system for Medicaid patients in nursing homes. It is based on the actual needs of the individual patient, not some arbitrary category that does not take the individual's situation into account. Ohio's "case-mix" system may be a model for the nation.

Further, a significant consequence of increased discharges of Medicare patients to skilled nursing homes appears to be decreased availability of nursing home beds for Medicaid patients. Obtaining a Medicaid bed has been difficult enough, and it promises to become even greater. As we learned at our hearing in October, 1984, Medicaid patients face signficant discrimination in obtaining or retaining nursing home beds. Ohio has enacted a tough anti-Medicaid discrimination law regarding nursing home care. Again, Ohio's law may serve as a model for dealing with some of the problems that the Aging Committee is hearing about.

Today's witnesses include two ombudsmen and the wife of a Medicare beneficiary who was helped by an ombudsman. The work of ombudsmen and other advocates for the elderly is crucial to assisting our most vulnerable citizens to find their way through bureaucratic mazes and to assert their rights to appeal decisions by Medicare and other programs that adversely affect them. This Committee is concerned about the Administration's support for the Ombudsman program. It clearly needs to be strengthened and made more widely available.

There is much that needs to be done to protect the rights of Medicare and Medicaid beneficiaries and to ensure that quality care is provided, as Congress intends. A few of the actions we need to pursue include:

Strengthening the appeal rights of beneficiaries denied Medicare coverage;

Informing beneficiaries of their rights;

Improving discharge planning in hospitals;

Examining the current classifications of nursing home care under Medicaid, and if appropriate, making changes that reflect the actual needs of residents; and

Improving Federal requirements for protecting nursing home residents.

Mr. Chairman, I look forward to joining you and other members of this Committee in pursuing needed legislative and administrative changes on behalf of the vulnerable elderly.

I appreciate the participation of today's witnesses. Many of them have come a long distance to inform us of their personal experiences or those of their clients. What each of you has to say will not only help to increase public awareness about these issues, but will assist us in pursuing legislative and administrative remedies to these very serious problems.

Also today, the Senate Special Committee on Aging is releasing an Office of Technology Assessment report, requested by Senator Heinz and myself, entitled, "Medicare's Prospective Payment System: Strategies for Evaluating Cost, Quality, and Medical Technology." This report should add a great deal to our knowledge about the overall impact of DRGs on our health care system.

Chairman HEINZ. I also am pleased that Senator Burdick, another very active member of the committee, is here.

Senator Burdick, if you have any remarks, and I imagine you might, please proceed.

STATEMENT BY SENATOR QUENTIN N. BURDICK

Senator BURDICK. Thank you, Mr. Chairman.

I want to say how much I appreciate the committee continuing this series of hearings on the impact of the prospective payment system. It is far too easy when we are here in Washington to focus on the bottom line. Certainly, the budget is important; we must keep a careful watch on expenses. But the bottom line is not the whole picture. That is the chief reason why we are here today.

In my opinion, we who are on the Special Committee on Aging have to be watchdogs for the elderly in our country. We have to stand watch to assure that decisions that are driven by the budget will not drive over the very people they are meant to assist.

When Medicare adopted the prospective payment system, we were told it was a system that would work to save money. Well, for my money, if the system is not taking care of our Nation's senior citizens, it is not working. If the system is discharging patients from hospitals "quicker and sicker," it is not working. And if the system places too much burden on nursing homes, on home health care agencies, and especially on the patients and their families, it simply is not working.

Mr. Chairman, we are here to see that the prospective payment system works. We must make sure that Medicare does not abandon those in our society who depend most on good medical care.

I know that our witnesses will make a much-needed contribution to our knowledge about the effects of prospective payment. I thank them for coming here today, and I look forward to hearing what they have to say.

Thank you.

Chairman HEINZ. Senator Pressler?

STATEMENT BY SENATOR LARRY PRESSLER

Senator PRESSLER. Thank you, Mr. Chairman.

I share in the concern for the posthospital care. I think this hearing is very appropriately timed, because a great problem is developing. Indeed, especially in rural and smaller cities, the speedy discharges from hospitals, encouraged by DRG's, may hurt some patients. This is doubly true in rural and smaller town areas because of the lower rate of reimbursement which is assumed because it presupposes hospital costs are lower in a smaller town or city. However, the opposite is true, because a 40-bed hospital cannot average out the cost of capital equipment over as many patients. Further, the wage scales are the same. For example, in small towns only 40 miles away from Rapid City, SD, you have to recruit the same nurses and the same doctors, at the same wages, and in some instances even higher wages. In fact, sometimes there is an opposite effect in terms of wages. In Minnehaha County, the largest county in South Dakota, there is the Sioux Falls wage rate, but in Dell Rapids, 30 miles away, it is assumed that they should be reimbursed at a lower rate because they have lower costs. Their costs are just as high because they compete for the same pool of nurses and doctors. Therefore, they have a higher capital cost per patient. Consequently, I think it is a very important thing that we are looking at here, because there is increasing pressure to get patients out of the hospital quickly, and this is harming some patients.

Let me also say that I hope we look at the nursing facility classifications under Medicare. Nursing facilities are classified as either "skilled" or "intermediate" care, and those classifications have caused a great burden in some areas.

The appeals process is also very complicated. Many individuals are not being told of their rights under the Medicare Program, and there is a lack of information on the Medicare appeals process.

Mr. Chairman, on another matter, I shall be sending you a memorandum, asking to update a report I prepared, "The 1984 Rural and Small City Elderly Report," which addresses the special problems that occur in counties and towns that are not metropolitan [statistical] areas—areas which geographically make up most of our country. It is not just a South Dakota special interest; I am sure it is an issue in Pennsylvania, Iowa, North Dakota, Ohio, and New York as well. The special problems of providing health care in nonurban areas need to be examined.

I presented this report to you in 1984, and I shall be updating that report by surveying the various States on the special problems they have encountered with Federal legislation.

Finally, Mr. Chairman, I shall be sending you a request to hold a special Alzheimer's disease hearing soon on some of the recent research and legislative initiatives, and a continuing examination of that disease, which causes so many admittances to nursing homes and hospitals.

Mr. Chairman, I shall submit the remainder of my statement for the record.

Chairman HEINZ. Without objection, your entire statement will be a part of the record.

[The prepared statement of Senator Pressler follows:]

PREPARED STATEMENT OF SENATOR LARRY PRESSLER

First, I would like to commend Senator Heinz for holding this series of hearings on Medicare DRGs, and their impact on health care. As you know, this is the second hearing in the series—focusing particularly on post-hospital care.

Since the enactment of the Medicare prospective payment system [PPS], many problems have developed which we are only beginning to examine. Understanding these problems, and developing legislative and administrative remedies is essential to the future of health care in this nation.

Coming from the state of South Dakota, I am particularly interested in hearing of the problems facing our elderly in the rural areas. In reviewing some of the testimony being presented here today, many of you have referred to problems with Medicaid discrimination, and outmoded health care facility classification system, and premature charges. These problems are compounded in rural areas where resources and dollars are even more scarce.

Let me add that the problems we are hearing of today are not exclusive to any one group. Americans are living longer, and therefore our elderly population is growing at a tremendous rate. Providing the quality health care which our senior citizens so greatly need and deserve, is a challenge which all of us must address. We need to provide long-term solutions to these problems—not short-term reactions. This is an effort which requires much more than "band-aids." And, it is my hope that Congress will hold many more hearings, such as these, and give health care the proper attention which, I believe, is essential to our future.

Chairman HEINZ. Let me thank you, Senator Pressler, for an excellent analysis of some of the problems that we are encountering. And as to the updating of your report on rural concerns of the aging and less-than-standard metropolitan areas, I well remember your 1984 report. It was of great value to me. I read through the recommendations from each of the States that you contacted. We, the committee, got a number of good ideas that both you and other members were able to followup on, and I not only anticipate your update with great pleasure, but urge you to get it, because it is indeed valuable.

And I look forward to holding again with you a hearing on Alzheimer's, as we did in 1983, as I recollect. It had a great effect.

Let me yield at this point to my friend and colleague, Senator Grassley. I have a special affection for Senator Grassley. He is not only one of the most active members of the committee, but both my mother and my grandmother come from his congressional district when he was a Congressman. He is now a Senator of distinguished note, but had my mother and grandmother not moved from Iowa, he would have been my Congressman, I imagine.

Senator GRASSLEY. I probably would have had more competition, right? Is that what you are trying to say?

Chairman HEINZ. I would never have had a chance to get into public service.

STATEMENT BY SENATOR CHARLES E. GRASSLEY

Senator GRASSLEY. Thank you, Mr. Chairman.

I appreciate the opportunity to participate in this, the second of a series of three hearings that I think you have scheduled for this committee on the Medicare prospective payment system.

As I mentioned in August, I think I mentioned this to you in the first of these three hearings, in August, I held a similar hearing in Iowa through my chairmanship of the Subcommittee on Aging of the Senate Labor and Human Resources Committee. In that hearing in Des Moines, we examined the built-in incentives in the prospective payment system for hospitals to discharge patients quicker and sicker and particularly how that was being handled in my State.

Witnesses from my home State testified at that time that patients are being released much earlier from hospitals and are being sent to nursing homes which are ill-equipped to address their heavy care needs.

Even more at risk are those Medicare patients with heavy care needs who are released to their homes in the communities that lack programs of comprehensive community-based care.

Clearly, the prospective payment system has put a strain on the availability of postacute care, and it has been well-established that resources and clinical management of postacute patients is inadequate.

Now, limitations on skilled nursing facility access and the narrow scope of home health benefits, combined with payment reductions, have resulted in many Medicare beneficiaries bearing the cost of these services out of pocket, or worse, simply doing without.

Additionally, we must recognize that the quality of care review provided by the peer review organizations in hospital settings is not available under current law to ensure a quality continuum of care. Expanding the role of the PRO's to review postacute care in nursing homes and home health care facilities would give us better data as to whether or not Medicare beneficiaries are being prepared for home care or are experiencing complications after hospital discharge for outpatient treatment.

My colleagues can see from the names on the desk that two of the witnesses today are from my State. I am especially delighted to note that these two witnesses are constituents of mine—Ms. Sue McDonough and Janet Adair are both from Osceola, IA, and I think will provide a very valuable perspective from the rural community where there are fewer available resources for postacute Medicare beneficiaries.

Ms. McDonough and Ms. Adair, I welcome you both here, and do not in any way have any reluctance appearing before those of us in the Senate. Feel at ease, and you will find us all very helpful in any questions we ask you. So, when you are asked questions, please feel at ease and do not feel any sort of restraint at all.

Chairman HEINZ. Thank you, Senator Grassley.

Let me yield to Senator Glenn so that he may introduce our first witness, and then we will introduce the others in turn.

Senator GLENN. Just very briefly, because we do want to get to the witnesses. As you are already finding out, when Senators have a podium, they tend to talk too long sometimes; we should be listening to you instead of making our own statements.

I am pleased, Mrs. Bell, to have you here with us, because I think you can give us a lot of very valuable testimony this morning.

Mrs. Bell's husband, Lawrence, is currently in a nursing home he was discharged following surgery in early August, and she is normally at the nursing home with him every day. She is giving up a day at the home to be with us to give testimony and to share the experiences they have had, and their difficulties in obtaining care. So her testimony will help us to set the stage for today's hearing and subsequent action.

So welcome, Mrs. Bell. It is an honor to have you join us today, and we appreciate your taking a day off to come.

Thank you very much, Mr. Chairman.

Chairman HEINZ. Mrs. Bell, you are our first witness. Please proceed. We are delighted to have you here, and as Senator Grassley said, do not let the bright lights or all the oratory from up here in any way daunt your enthusiasm or good nature.

We are delighted to have you.

STATEMENT OF MARIE BELL, MAYFIELD VILLAGE, OH

Mrs. BELL. Good morning, Senators. My name is Marie Bell, and my husband Lawrence and I live in Mayfield Village, which is a suburb of Cleveland.

I am here today to share my horror story, with my husband's experience with Medicare. I want to give you some of the background so that you understand the pain and the mental anguish that we have been through. We have suffered, and we are still suffering. We are not finished with this situation.

My husband is 72. He is legally blind, because he is a diabetic, and he is a double-amputee, 6 inches below the knee. He also has a history of being manic-depressive. He worked until he was 68 years old. I am 64. I suffer with hypertension, and I have a heart condition which requires a pacemaker. Our only income is Social Security.

At the end of January of this year, abrasions appeared on my husband's foot. On June 26, his cardiovascular surgeon advised amputation, because the abrasions became gangrenous. The pain was so intense that he wanted to die. He became bedridden.

On July 3, at my insistence, our HMO agreed to send an ambulance so that he could be evaluted. We were told that because this was not a new situation, he could not be admitted to the hospital because of the guidelines that they had to work with.

I begged the doctor to admit him, even for a few days, because I was the only caregiver available, and I needed time to work out some kind of a support system to help take care of him. But they sent him home anyway. They said they could not admit him at that point.

July 5, which was 2 days later, the HMO agreed to send an R.N. to evaluate his condition because I found he could not move. I guess it was this intense pain that he was in. They agreed to pay for a home health aide for 3 days; it was sort of an emergency measure, for 4 hours a day, for the 3 days that weekend.

Medicare allowed a home health aide to come in for only 2 hours a day, 3 days a week, and a registered nurse just a little bit in the morning, to take his vital signs and give him insulin. That went on for about 10 days, and she then taught me to give him the insulin.

It was impossible, really, for the aide, in a 2-hour span, to take care of his most urgent needs. His feet had to be taken care of; the abrasions and so forth, and to bathe him and do all the things that were just urgently necessary were not possible in that timespan.

So we had to pay for the extra time. We needed minimally 4 hours a day to handle the situation. So from our meager savings, we had to pay for the aide for the 4 hours a day to make up the difference, because we were only getting 6 hours a week from Medicare. And I was the private-duty nurse the remaining 20 hours.

Believe me, it was very difficult. First of all, he is a large man. He is 6-foot-3, 200 pounds, and I had great difficulty in just even trying to move him. I could not. And with my heart condition, I was really frantic. I did not know what to do.

Then, my husband began calling for pain medication every hour. Gangrene developed on his other foot. The doctor agreed to admit him to the hospital on July 23. Changes, he told me, in his condition, were within the Medicare guidelines. My husband refused to go because he feared amputation. Finally, with the help of our doctor, my husband realized he was endangering my health, and he agreed to be admitted on July 27.

On July 28, our entire church prayed. A miracle happened. He agreed to surgery, which was scheduled for August 2.

On August 9, 1 week after his legs were amputated, the hospital released him to a nursing home. My husband could not sit, he could not turn in the bed at all. He could not help himself to turn. He could not swallow; he had difficulty swallowing. Again, I was told that the guidelines required that they release him to the nursing home.

The 20th day—and this was the most traumatic thing that happened to me—on the 20th day of his stay in the nursing home, which was August 28, the social worker called and told me that he was being dropped from Medicare. The reason was that he could not wear prostheses because of his blindness, and that the likelihood for complete rehabilitation was not there.

At this point, I want to make it clear that I never set that kind of goal. I did not think it was realistic. I would be satisfied if my husband could be taught to transfer himself, say, from the bed to the wheelchair and vice versa.

He is considered to be in custodial care now, and in reality, he is receiving therapy. And one thing I do not understand is why physical therapy is not a specialized care or a professional-type care. How can he be custodial, when he has to have this therapy to live a reasonably decent life and be able to handle himself somewhat?

On August 29, I received a bill which was payable by September 4—mind you, this was the Labor Day weekend—for $2,048. This would cover the last 2 days in August and all of September. I paid this out of our dwindling savings.

Now, with the help of the ombudsman, I appeared for reconsideration on this decision to cut my husband off from Medicare. The nursing home called the fiscal intermediary and was told the decision stands. I was advised by the insurance company to have the nursing home bill Medicare directly. This is supposed to trigger a denial letter which is necessary in the appeal process.

Since, I have discovered that until this day, the billing has not been submitted because I understand that they have to receive an acceptance—the nursing home must receive an acceptance in order that they bill Medicare directly—and they still have not received it. So I am in limbo.

In the interim, I have been billed for another month, and I do not know what I am going to do.

I guess my husband and I kind of lived in a fantasy world. We thought that our needs were going to be met, because he has membership in an HMO; he has extended insurance; he had Medicare, and they all used the same guidelines, the Medicare guidelines. And we actually face the possibility of becoming destitute.

And the thing I do not understand really about the guidelines is how the expectations for a blind, 72-year-old man can be the same, say, as for a 52-year-old sighted person. I mean, those expectations certainly were not fair or realistic.

How can my husband be ready in 20 days for prostheses when he was bedridden for weeks, and he could not even sit or move? How could that be possible? He had to start from square one.

The question I have in my mind is, is my husband being discriminated against because he is old and because he is blind and because he does not have legs anymore? I got the feeling through this whole traumatic experience that we are using our tax dollars for the younger segment of society and dumping the older members, who worked hard and never asked for anything; we never asked for anything. We just wanted reasonable care. We thought we were providing for that.

And the other thing that bothers me is why isn't the Ombudsman Program more widely known? At this point, I will just take a moment to tell you how I found out about it. Nobody came up to me and said, "There is an Ombudsman Program to help you"—no. My husband's daughter happens to be an R.N. who is not practicing her profession at the moment in Rochester, NY, and had a friend who attended a seminar for nurses. And she had heard about the Western Reserve Committee on Aging in our area, and also about the ombudsman. They gave me the number for the ombudsman office, and that was how I happened to call. It was quite a circuitous route by which I found out about it.

If I had not had that contact, or she had not, I would never have known about this.

It just does not seem right that my husband and I have worked all our lives and have given and given, and now we feel like we are being abandoned, we really do.

Senator Heinz and Senator Glenn, I do hope you will be successful in getting answers for us. There are many other people, I am sure, who can tell you similar stories.

My mission in life now is to make these inequities known so that constituents can bombard their Senators and Representatives for relief from this—because I go to this nursing home every day, and I hear stories, I hear stories. Just going there, I have had a liberal education in the last 3 months. Thank you.

Chairman **Heinz**. Mrs. Bell, first of all let me say I think we all are deeply touched by your testimony, and we know it must be terribly difficult for you to relive these past few months.

Mrs. **Bell**. Yes, it is.

Chairman **Heinz**. Your good nature comes through when you describe it as a liberal education. It sounds to me more like a series of horror stories.

Mrs. **Bell**. Precisely.

Chairman **Heinz**. I do not think there is any member of this committee who wants you or any of the other Medicare beneificiaries to feel abandoned. And as difficult as it is for you to tell your story, thankfully you were fortunate enough to find an ombudsman so that you could pursue some of your rights. There are so many others who never found an ombudsman, who were not able to pursue some of their rights. Your story is nonetheless going to be extremely helpful to avoiding the repetition of this, which I fear is taking place over and over again. So you are performing a genuine public service to us all in being here. And for that, I think we are all—Senator Glenn, I know, in particular—but I think we are all deeply grateful to you.

Again, thank you, and we will have some questions for you.

Mrs. **Bell**. Thank you.

Chairman **Heinz**. Let me next call on Dr. Lydia Thomas.

STATEMENT OF LYDIA THOMAS, PH.D., GAITHERSBURG, MD

Dr. **Thomas**. Good morning. My name is Lydia Thomas, and I am a resident of the State of Maryland.

I appreciate the opportunity to testify here today and to share with you the nightmare experience of my 75-year-old mother after a very serious automobile accident that occurred in January of this year.

To give you some indication of the severity of the accident, I can tell you that she was in a brand new automobile that sustained $6,000 worth of damage; I think it is on a trash heap someplace.

Following this accident in her hometown in Virginia, she was rushed by ambulance to a private hospital, with severe bruises and abrasions all over her body. She also had three very large lumps, if you will, about the size of golfballs, on her head. She was examined in the emergency room and x rayed for internal injuries. Fortunately, no bones were broken, but due to the severe trauma to her hip and the substantial bruises, she was unable to walk.

The physician told my mother that although he could not tell from the x rays and the type of examination that he had been able to administer in the emergency room facilities, that he feared the possibility of some head injury.

My mother was very frightened. Because of her condition, realizing that she could not move around, she could not walk, and being told of head injuries, she asked to be admitted to the hospital. But the doctor replied—and he later told me, as well—that Medicare did not cover hospital admission for observation. Instead, she was released an hour or so after entering the emergency room, with the following instructions: "Patient should be awakened every 2 hours throughout the night; apply ice packs to bruised areas; if any nausea, vomiting, dizziness, et cetera, occurs, return immediately to the hospital."

She was asked to sign a release absolving the emergency room from any responsibility and acknowledging that she understood the instructions.

Did it matter to the hospital that my mother lived alone in a two-story house, and that she was still suffering from residual effects of shock? Obviously not. Did it matter to the hospital that she would have been willing to pay for the hospital stay out of her own funds? They did not bother to ask her. Did the hospital expect my mother to wake herself up every 2 hours, as the instructions required? Who was to prepare the ice packs and replace them?

I am her only child, and I live over 200 miles away. Fortunately, her 73-year-old sister and her 74-year-old brother-in-law managed to get my mother home that day. I should add that she was sitting in the car in front of her house for approximately an hour before we found someone physically strong enough to carry her to the second floor of her home.

Chairman **Heinz**. Did she drive herself home?

Dr. **Thomas**. No; my 74-year-old uncle managed to get her home.

Until I could leave my job and be with her, we had to press neighbors into service. She was so bruised and sore from the injuries she sustained in the accident that we had to supply her with a wheelchair when we were finally able to move her, which was approximately a week later. She was totally bedridden for at least a week and remained in the bed or in the wheelchair for approximately 3 weeks.

We thank God that she is alive, but her recovery was not due in any way to the care that she should have received at the hospital. To have sent her home to care for herself was outrageous and unforgiveable.

My mother has worked hard all of her life. She was a teacher in that town for 40 years. My father served on the board of directors of the hospital that discharged her. When I ask myself how this could have possibly happened to my mother under those conditions—if any of you gentlemen could have seen her, even without medical training, it would have been abundantly clear that there was no way she could care for herself, that she required professional help—my only conclusion is that it happened to her because she was old. "Old" means Medicare, and Medicare now seems to mean do as little as possible, if anything at all.

I strongly urge this committee to do everything in its power to expose and correct this absurd and callous abuse and neglect of our country's senior citizens. I truly fear for the future of a country that is willing to discard ose who have given it a past. Thank you.

Chairman HEINZ. Dr. Thomas, we thank you because it is through your real life experience that you are helping us to understand the truth, to be fully exposed to it, so that people who want to be ignorant of the truth—and I fear there are too many of them in the bureaucracy of government that is supposed to serve the people, but have forgotten what their mission is and who simply do not want to know what the facts are.

We thank you very much, and we will have some questions for you.

Let me now turn to Senator Grassley's constituent, Mrs. Susan McDonough.

STATEMENT OF MRS. MARCIA SUSAN McDONOUGH, OSCEOLA, IA

Mrs. McDONOUGH. Good morning. My name is Sue McDonough, and I live and work in a small town in south-central Iowa.

On May 3, 1985, my father entered a hospital in Des Moines, 50 miles from his home. He was told he had a very large aneurysm attached to his aorta. On May 7, my father underwent major surgery to correct this problem. This surgery was so extensive that they told us later it was one of the worst ever done in that hospital. The hospital is well-known for heart surgery in the Midwest.

Four days after his surgery, my father went into kidney failure and was put on dialysis. He was in intensive care for 3 weeks and in the hospital for a total of 6 weeks. During that time, his wife, my stepmother, was going through eye surgery at another hospital 200 miles away.

On June 16, the hospital discharged my father and sent him home with instructions to return to Des Moines three times a week for dialysis. This is a 120-mile trip. The doctors also told him that he had to go on a strict diet because of the dialysis, and gave him written instructions.

The hospital did not tell us anything about Medicare paying for home health care nurses. So they sent him home to my stepmother, who had just had eye surgery and could barely see. My father was very weak and very depressed, to the point of not talking, and mostly when he tried to talk, he cried.

My father's special diet is so complicated that a person with good eyes would find it hard to follow. But my stepmother could not even see well enough to read the menus and the ingredients. She could not read the medication instructions, and so many times he took the wrong medicine, or too many, and they would call me from work, and I would have to go over and see what trouble he was in. So I would go by their house on my way to work, on my lunch hour, after work, to help with their groceries and medications, in addition to caring for my own husband and three children after work.

On top of all this, my brother and I took turns driving my father back and forth to Des Moines for dialysis three times a week.

The 120-mile roundtrip for dialysis was very tiring for my father. Each time his depressed attitude would worsen, and I knew he needed help. He could not sleep, could not eat, barely walked and would hardly talk.

Finally, about 10 days after his discharge, I found out about Medicare paying for home health care nurses, and I called the county health department. Medicare paid for a nurse and an aide to visit my parents three times a week until it ran out this past July after 30 days. Having the nurse and aide to come in like that was a big help and necessary. The only trouble is that it did not last long enough. As shaky and as weak as my father still is, my mother depends on him to put the drops in her eyes. And even though my stepmother is legally blind, she is trying to do what she can do to take care of him.

It seems like the hospital should have told us before my father was discharged about Medicare paying for home nursing visits. I also do not understand why Medicare would not continue to reimburse for home nursing visits when both my father and my mother really needed that nursing care. Thank you.

Chairman HEINZ. As I understand it, Ms. Adair was the home health nursing administrator who arranged the care for your father, Ms. McDonough, is that right?

Ms. McDONOUGH. Yes.

Chairman HEINZ. Ms. Adair, what is your assessment of the situation in this case, could you rell us?

STATEMENT OF JANET ADAIR, R.N., OSCEOLA, IA, HOME HEALTH NURSE

Ms. ADAIR. It is not uncommon for us to see such a home situation as this today. There were several things going on in Mr. Querrey's home. He was so sick before he left the hospital that the nutritionist was unable to talk with him about his very important diet, that is individualized for each renal dialysis patient.

In addition, his wife was undergoing cataract surgery at Iowa City and had stitches in her eyes, so her already visual impairment was worse than usual.

Also, there was a role reversal going on in the home. Sue's father had always taken care of her stepmother because of her visual impairment, and in fact, when he returned home, there was a role reversal; now she was having to care for him. This was very hard for him to cope with, because he had always been a very strong, healthy, outdoorsy type of person. So there was a lot of emotional upset going on in the home between the family members—the children, Mr. Querrey and the wife. There was a lot of coping that was going on.

Before any of the physical things could be taken care of in the home through skilled nursing, they really needed to resolve this emotional upset first.

Sue's three areas that she was concerned with when she called us were: (1) meal planning, (2) Mr. Querrey had six medications that had to be taken at various times during the day, and (3) he was also instructed to feel for his left radial pulse to determine if the shunt site remained open, which would need an emergency visit to the hospital if it were not. He was unable to even feel for the shunt, let alone receive any instruction for that.

Chairman HEINZ. I understand that you have a written statement for the record, and it will be made a part of the record.

[The prepared statement of Ms. Adair follows:]

PREPARED STATEMENT OF JANET ADAIR, R.N.

I am a Public Health Nurse Administrator for a home health care agency in rural Southern Iowa serving a county of approximately 9,000 people. Clarke County is primarily a farming community with approximately 22% of the population being 60 years of age or older. Because of the many elderly and due to the farm crisis that we're all aware of, it is a financially stressed area. Living in a rural area frequently means fewer choices in health care or fewer community resources to draw upon, than one would have in a more urban area. As a result, the community hospital becomes very important to all of us.

I set up the Clarke County's Public Health Nursing Agency 10 years ago and have observed many changes in health care since that time. I had always felt good about the quality of health care I observed being provided to our patients in southern Iowa. However, since the implementation of the DRG's and perspective payment plan, the quality of health care has declined. As a result of DRG's, hospitals are struggling to meet their expenses—seeking ways to generate more income—thus implementing their own home health care agencies which has had a direct effect upon us. Public Health Nursing Agencies in our area have noted decreased hospital referrals, decreased continuity of care for the patient between hospitals, doctors, and rural home health care agencies, as well as decreased cooperation. More outpatient services are being performed. Numbers are becoming more important then the actual individual patient when we talk of being cost effective. Increased numbers means a lower cost per service. Thus, the more patients served, for a shorter time period of care, the less expense to the institution.

As a result, we in the home health care field, are seeing an entirely different type of patient than we did 3 years ago. Instead of providing preventive health care and education, maintenance, or restorative types of services, we are now serving a client in need of more skilled nursing care than ever. The patient is being discharged from the hospital sooner, many times unable to care for themselves in the home without much assistance from others. We have observed patients being sent home with Hickman Catheters, with instructions to administer their own IV antibiotics or do their own catheter care, patients being sent home requiring chemotherapy or IV therapy in their own homes, patients being sent home with very little, if any, patient education on their disease processes, medications or special diets as illustrated in several case studies submitted to you; patients being sent home with large gaping, infected wounds requiring daily home visits to clean, pack and dress the areas. These are patients who 3 years ago would have been kept in the hospital for a longer period of time. But today, they are sent home only to require frequent rehospitalizations, placement in nursing homes or even die. Our agency has observed an increase of deaths and nursing home placements in the last year. (Refer to table).

Discharging the patient earlier or having them obtain their care through out-patient services in the hospital also places additional burdens on our clients such as arranging for transportation and transportation expenses to Des Moines, Iowa (50 miles away) with family members many times having to leave their jobs to assist with care, meeting appointments or providing transportation for the patient. While it may be decreasing the financial burden on the institution and the Medicare-Medicaid programs, it is increasing the financial burden on the patient and family.

Home Health Agencies are also experiencing an increased financial burden as the Medicare and Medicaid programs are not reimbursing for services they once were, or have decreased the percent of reimbursement to the provider, as Medicaid did this month from 97.5% to 92.14%. As a result, because patients are already financially stressed, we are providing more and more free service as evidenced by the additional statistics provided to you for reference (Table 9). We are wondering how much longer non-profit public health nursing agencies will be in existence with the Revenue Sharing monies we depend on so heavily being cut each year, the Medicare and Medicaid programs decreasing the amount of money to the providers as well as private insurance companies not covering many home health services such as home health aide care—the families can't subsidize our services in this day and age. Many are asking, "Why pay such high premiums or why have Medicare coverage when it pays for so little?"

As for myself, I'm questioning, "How can we rationalize being educated as health professionals to treat each patient as an individual with each having special needs, disease coarses and healing rates, and then turn around and place each patient's health disorder in a disease classification or code, expect them to recover within a specific time frame for a specific amount of dollars?" How can we as individuals expect to receive personalized care with a system so impersonal, and dehumanizing?

Chairman Heinz. You state that, "The quality of care has declined since the implemenation of the prospective payment system and DRG's." Just briefly, drawing upon your 10 years of experience as a home health nurse, what is happening to patients now that was not evidenced prior to the implementation of this prospective payment system? Do you see some big changes?

Ms. Adair. Yes, we have. We have seen a totally different type of patient now than what we did, let us say, 3 years ago. They are coming home from the hospitals sooner; are being sent home with Hickman catheters; instructed to administer their own IV antibiotics in the home; to do their own catheter care. Patients are being sent home with requests for chemotherapy in their home and other IV therapy. They are sent home with very little, if any, patient education on the disease process, the medication, signs and symptoms to observe for and also special diets, as illustrated in Sue's case.

These are patients who would have been staying in the hospital longer 3 years ago.

Chairman Heinz. I have some questions, but my time is about to expire, and I want to yield to Senator Glenn because I am sure he may have some questions.

Ms. Adair, thank you very much for your testimony. We deeply appreciate it.

Senator Glenn?

Senator Glenn. Thank you very much, Mr. Chairman; I do indeed.

Mrs. Bell, let me make sure that the committee understands the key points of your testimony. Your husband was discharged from the hospital just 7 days after his legs were amputated; is that right?

Mrs. Bell. That is correct.

Senator Glenn. And he then went into a nursing home, and just 20 days later, you were told that Medicare would no longer cover him there; is that right?

Mrs. Bell. That is exactly right.

Senator GLENN. And you are now appealing that decision, as I understand?

Mrs. BELL. Yes.

Senator GLENN. But you do not have any indication of how that appeal will go?

Mrs. BELL. It is such a slow process. As I indicated earlier, they have not even submitted the first bill; they are waiting for this acceptance letter. And so the procedure is that we bill Medicare directly and receive the denial letter which is necessary for the appeal process.

Senator GLENN. If that appeal is denied can you tell the committee how you will pay your nursing home bills?

Mrs. BELL. Well, I am going to have to bring him home, because I just will not be able to afford to keep him there.

I do not know if you want to know this, but we are paying $64 a day, plus $20 a day extra for therapy, and we are paying for rental of the wheelchair, we are paying for medication. I calculated that for the 2 months and 2 days which we are paying for, plus $350 which I spent for in the home care prior to surgery, we have spent $5,245.

Now, I am going to bring him home, because I just cannot pay for it. I am going to try to work up a support system. I do not know if it is a good decision—I am sure it is not. He is not ready. He cannot transfer himself.

And I can take care of the meals and the laundry and things of that nature, but to handle the man—it scares me. But I have no alternative. I am in limbo now on the appeal, and I just do not know what I am going to do.

Senator GLENN. You were told several times that Medicare coverage for his care was being terminated and was no longer available for the level of care that your husband was at.

Mrs. BELL. Correct.

Senator GLENN. And 1 week after his legs were amputated, he was out of the hospital—20 days after he was in the nursing home. So that just 27 days after the amputation, you were told that Medicare would no longer pay for the nursing home care because he was not likely to be fully rehabilitated.

Mrs. BELL. That is correct. They told me that if at that point he had been able to wear temporary, even temporary, prostheses, he would have been kept on. But that was impossible. And I never even thought that as a goal. I merely wanted them to rehabilitate him sufficiently so he could be somewhat mobile, to be able to transfer himself from the bed to the chair.

Senator GLENN. Well, at either one of these health facilities, were you ever told you had a right to appeal these decisions?

Mrs. BELL. No. The nursing home mentioned it after I had spoken to the ombudsman and went there and asked them to call the fiscal intermediary. Then she mentioned it as a little insert after I had made that request. I was never told that. I learned of this whole procedure through my husband's daughter in Rochester, as I related to you.

Senator GLENN. Well, Mr. Chairman, I do not know how we make the Ombudsman Program more widely known and how we get information around on this.

Perhaps Ms. Adair could comment on that, because you are in the provider services. How do we make the Ombudsman Program better known? Do you inform people of this program? Do you tell them what their rights are when they come to you?

Ms. **Adair**. Just in the last year, this has been an issue brought to our attention by our fiscal intermediary. Our nursing agency was certified at the end of 1982, and when we became certified, they did not give us an instruction manual as to how to interpret the rules and regulations, or how to bill, or anything. So the educational process from the Medicare intermediary to the nursing agencies is very poor. So the nursing agencies themselves may not be aware of all that is involved in the appeal process.

Senator **Glenn**. I have a another line of questioning—the chairman started off on this—which I would like to followup just a little. I know we are short on time, Mr. Chairman, but when you say that implementation of the DRG's and the prospective payment system is resulting in less care and in downgrading care, instead of providing more care and better care, then that gets to be a very serious concern; we are on the wrong track. We know that health care costs have gone up tremendously, and they have to be addressed. I can put another hat on and argue this whole situation from the hospitals' side. Their costs are going up, and they have to do something about it. And we have problems at the Federal level. So, the prospective payment system and the DRG's were an attempt to get a handle on that.

But what you are saying here, and we have heard this from some other sources also, is that this is having a monstrous impact on the quality and the length of medical care.

What is the answer? Give us some advice.

Ms. **Adair**. It is true that the more people you see, the more patients that you turn over, it lowers your costs. But there again, you are becoming more concerned with numbers and statistics instead of the quality of care.

There is no way to get around it, that to provide quality medical care it is going to take some time.

Senator **Glenn**. Do you think we should do away with the PPS and the DRG system now? Has it had a bad enough impact—have we had enough experience now to know that it is mot working?

Ms. **Adair**. In the 10 years that I have been in home health care, the quality of care was much better before the DRG's were activated. Patients had better discharge planning prior to the DRG's becoming effective.

Senator **Glenn**. Well, we may want to submit some more questions for your comments because you are a provider; you are one who sees it from both sides. You see it from the point of view that Mrs. Bell is talking about, and the other people are talking about, and yet you see the other side of it also, as to what has happened under the PPS and the DRG system. I know we do not have time to continue this for very long this morning, but we might want to submit more questions to you and have you answer them, if you would please, for the record; we would appreciate that.

Thank you very much, Mr. Chairman.

Chairman **Heinz**. Senator Glenn, those are excellent questions.

I would only add that we are going to have in our next panel a series of discharge planners and experts who can augment Ms. Adair's excellent testimony.

There is one question before I yield to Senator Burdick that I want to relate to Senator Glenn's questions.

I understand that in Iowa some home health agencies are required to provide and must provide continuing care to patients even after their Medicare stops. Is that correct, and if so, how well does that work in practice?

Ms. ADAIR. The way we are set up in Iowa, we have public health nursing services in all the 99 counties. When you are set up, your philosophy statement says that you will serve clients regardless of their income, socioeconomic background and so forth, so that you will not discriminate.

One of the questions since our Medicare numbers have dropped statewide as far as the number of Medicare patients that we have served who have been eligible for reimbursement is, Are you seeing the Medicare patients as well as the other patients, or are you just singling out the Medicare patients. And what they are looking for is, are you discriminating.

Yes, we have to serve patients regardless of whether the service is provided for free or not. And as a result, in our fiscal year 1982-83, we provided $2,162 worth of free service for that year. In fiscal year 1984-85, we provided $14,120. So you can see what the increase is for our small agency.

Chairman HEINZ. That is a very dramatic increase.

Ms. ADAIR. Yet we have had to increase our staff to meet the urgent needs of the patients coming home from the hospital.

Chairman HEINZ. Thank you.

Senator Burdick?

Senator BURDICK. Thank you, Mr. Chairman.

Mrs. Bell, you may have made a greater contribution to our senior citizens that you realize. I was not too familiar with the Ombudsman Program, and I think your testimony today is going to give emphasis to it.

Now, will you tell the panel what value and what benefit you get from the Ombudsman Program, for the record?

Mrs. BELL. Prior to my association with them, I had tried to make some calls on my own. I called the 800 number for Social Security to try to get a line on what the situation was and so forth. And it was very difficult to get a clearcut picture of things. I would get different answers from different people and agencies and so forth.

So, when I came in contact with the Ombudsman Program, I felt immediately that they were supportive. They listened, they evaluated very quickly what I had told them, the key points, and they proceeded to inform me as to what my procedures were. And they have been walking me through the procedure, at which we are stymied now, because of what I related to you. But they have been very supportive, and I felt very confident that I was getting bottom line information. And that is the value—I mean, when you are emotionally upset, it is like a catch 22 in a sense—and they are there, and you know it. And when I had experienced something at the nursing home, and I called the Ombudsman's office, I always got an answer, and a correct answer.

Senator **Burdick**. In other words, they expedited all the procedure.

Mrs. **Bell**. Yes, and it was supportive, emotionally and otherwise, to know that I had someone I could turn to when something developed that I did not understand, or they would tell me something there and it was like doubletalk to me. I am just a consumer. I do not understand the intricacies of their paperwork. And at least the ombudsman was able to clarify things so that I thoroughly could understand what they were talking about, especially in this acceptance business and this billing and so forth.

Senator **Burdick**. So one who had no knowledge of what the services were would be at a handicap, wouldn't they?

Mrs. **Bell**. Yes, I should say so. It has been a blessing to us. I mean, my husband, too, has been upset by all these things. I do not bother him with every minute detail. But you know, he is very worried about his future. And when I told him I had found the ombudsman, he was delighted to hear it. He thought, well, now maybe we can get some real answers.

Senator **Burdick**. Mrs. Bell, I think you made a contribution to this hearing today just by mentioning this fact of the ombudsman, and I appreciate it.

Thank you, Mr. Chairman.

Chairman **Heinz**. Senator Pressler?

Senator **Pressler**. I want to thank all of the witnesses. I think they have informed us of a very serious matter. Many of us hear similar stories in our constituencies when we are home in our States.

I do think we need to do one thing, that is to have staff, or someone from downtown, prepare a memorandum on some of these cases. I know under the Privacy Act, they cannot be directly responded to. However, in cases such as this, what regulations are there that come into effect? Are these the results of legislation that we have passed in Congress, or are they the result of arbitrary regulations being issued? It could be that we need new legislation, or that some things we are doing up here create situations such as this.

The other side of the story, is that there is a great effort on the part of the departments to save money where there is truly waste or where there have been abuses. However, these cases before us today are not waste or abuse; they are tragic human cases.

I have been reading through the draft of the impact of Medicare's prospective payment system. I wonder, Mr. Chairman, if a brief analysis could be done by staff, for me, and I hope for the whole committee, examining which guidelines come into effect, and if they are the result of regulations, or are they things that we have mandated. We need to dig back into this to find out where we can correct the problem.

Perhaps a witness for Medicare will be appearing at some point in the future, but I think that is something that would be very useful to me.

Chairman **Heinz**. Senator Pressler, thank you.

I also want to note, especially for the benefit of Ms. McDonough and Ms. Adair, that Senator Grassley had another committee meeting, the Judiciary Committee.

Sitting in his seat is Senator Lawton Chiles, of Florida, who has been a real asset to this Committee. Lawton, we are delighted you are here, and I would be happy to yield to you.

STATEMENT BY SENATOR LAWTON CHILES

Senator CHILES. Thank you, Mr. Chairman. I want to commend you and Senator Glenn for holding these hearings on the impact of DRG's on post-hospital care for Medicare beneficiaries, and I certainly want to commend the panel for sharing their experience with us. I think it certainly helps us.

I join in the belief that this issue is one of the most pressing that we will face in the near future. And like you, I have heard a lot from folks back home on this matter, and I am sad to report that little of it has been good.

I was talking to a nurse in charge of screening possible patients at one of our Florida nursing homes, and some of the cases she shared with me were very disturbing. She told me about a call she received from one of her local hospitals, and they wanted her to admit a 64-year-old woman to the nursing home. When she visited the hospital to see the patient, she found out the woman had been on a respirator for 5 or 6 weeks with a breathing tube down her throat. Her condition was not yet stabilized, and now, only 6 days later, the hospital wanted to discharge the woman because her Medicare days had run out. That is simply not right. Until the hospital gets the woman's condition stabilized, there is no way in the world they should be talking about discharging her.

She also shared with me about an 84-year-old patient whose blood sugar level was going from 40 to 800 within a 24-hour period, and the hospital wanted to discharge her to a nursing home.

And the reason in both of these cases is that, of course, the Medicare days have run out.

The examples were somewhat unusual in that the nursing home had a nurse charged with the responsibility of screening prospective patients. In all too many cases, the nursing home may not have someone who is screening those, and the patients are simply dropped on their door, and they are unstable and unsuitable for that level of care.

Obviously, that was not what we had in mind when we passed the health care cost containment measures that contained the DRG's. And while I believe that we did have to act to hold down the ever-spiraling costs of health care, I do not believe that any Member of the Senate wanted to achieve that goal by failing to provide proper care.

Another thing that concerns me, Mr. Chairman, is the failure of the Department of Health and Human Services to live up to its responsibilities. Two reports mandated by Congress to determine the impact of DRG's are months overdue. The Department has tried to make matters worse in the area of home health services by issuing administrative regulations limiting payment for those services. I have joined with you, Mr. Chairman, and others in legislation to preclude these actions.

I have also joined with several of our colleagues in sponsoring legislation aimed at making it easier for States to apply for waivers to provide community based care services so that all proper levels of care are available to them. In many cases that I have heard about, it seems to me again the Department is being penny-wise and pound-foolish; they are missing the whole point of what we are talking about and what Congress is trying to do, because of not taking humanitarian and relatively inexpensive care of some of our beneficiaries early on, and then we wind up with tremendos heartache as well as increased dollars.

For the life of me, I cannot understand how HHS just sort of seemed to put roadblocks in, as opposed to trying to make the situation work.

Mr. Chairman, I want to bring another incident to your attention today and to the attention of our other colleagues and Senator Glenn on the committee. Two days ago, I received a letter from a Mr. Enrico Stentella, in Port Charlotte, FL. It is a short letter, and I would like to just share it with you.

It says:

> Dear Senator, I do not know if you are aware of the latest injustice in our Medicare system by the powers that be. Medicare can no longer supply our doctors or us with free Medicare forms. I called the Medicare office in Florida for a verification, and was told that in the interest of economy we would now have to pay for these forms. This is an unfair cut for economy's sake. It will put much stress and unfairness on many of our senior citizens and make it difficult for them to apply for repayment. It makes me ashamed of this great country of ours for economizing on the pain, misery and suffering of our elderly.

That is his letter, Mr. Chairman. My staff thought there had to be some misunderstanding on the part of Mr. Stentella, so they called the Florida intermediary. He had not misunderstood; the Health Care Financing Administration put out a transmittal notice [1] on September 10, stating that they will no longer provide free Medicare billing forms free of charge to the physicians, computer firms, hospitals, and other providers of service. They will now have to purchase them.

I am glad that whoever thought this up is not in the Treasury Department, or the next thing we would have to purchase our 1040 forms and the other things.

Chairman HEINZ. Do not even suggest it, Senator Chiles. [Laughter.]

Senator CHILES. In the interest of fairness, we have found out that free forms will be available from the Social Security offices for the beneficiaries, and I guess from the intermediary, but not for their doctors or their hospitals, the people they go to, the people they see. So that means, I guess, if the doctor tells you that they will not accept assignment, you can get in your car, or get the bus, and go to a Social Security office, and they will give you a free form.

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[1] See p. 142.

I have done a quick check to just try to find out what other required government forms have to be purchased, and so far, Senator Glenn, I have not come up with any.

Senator GLENN. That is the dumbest thing I have ever heard of.

Senator CHILES. I cannot understand the logic that calls for putting further roadblocks in the way of sick and disabled older people for their Medicare benefits. Moreover——

Senator GLENN. Do you know what the charge is?

Senator CHILES. I do not know that I have that answer for you.

Moreover, the committee knows full well that if the provisions are not made in the transmittals precluding passthrough of the cost, the next complaint we will be getting from the beneficiaries is some of the providers selling the forms for inflated costs. Obviously, if the provider is going to have to pay for the form, they will add it in their overhead cost, so we can anticipate that happening.

Just this week, I had to propose an amendment to the HHS appropriation bill to stop them from eliminating Social Security staff positions that would have required closing field offices. In some cases, it might have required beneficiaries to drive for an hour or more until they could get to their nearest office. I want to announce today that I am going to take action as soon as I can to stop this, and I seek your support.

Chairman HEINZ. Senator Chiles, I join you as a cosponsor of whatever legislative vehicle or action you are going to take.

Senator CHILES. Well, I would love to have you and Senator Glenn both join me. I did find this bulletin from Blue Cross/Blue Shield, in which they say about the HCFA 1500 forms: "We have been recently notified by Health Care Financing Administration that they will no longer provide or pay for providing the HCFA 1500 forms to carriers or users of the form. We have been instructed to inform you that you may purchase the claim forms on the open market." And then they give them the Government Printing Office and the Superintendent of Documents and the American Medical Association, and they say they are currently studying the feasibility of providing the forms at cost, whether they will get into the business of supplying them at cost.

But Mr. Chairman, when we are trying to get doctors to take Medicare patients on assignment, when we are trying to get them to use the forms, when we are trying to provide some help, it is unbelievable to me—I guess this is an example of the mindset that has to be there, that you are going to charge doctors for this kind of form. I just cannot get my mind around it.

[The form referred to follows:]

BULLETIN

Blue Cross
Blue Shield
of Florida

Important Medicare B Information For Physicians And Suppliers

September 1985

NEW TELEPHONE NUMBER ESTABLISHED FOR PROVIDER INQUIRIES

The Health Care Financing Administration (HFCA) has recently advised carriers that it will no longer fund toll-free service to physicians and suppliers.

As a result, effictive October 1, 1985, physicians and suppliers may no longer use the beneficiary toll-free watts line (1-800-number) *unless* the call is in reference to one of the following:

- The call is on behalf of a beneficiary who is currently in the physician's office
- The purpose of the call is to provide answers to additional development requests on non-assigned claims.

A new group of telephone specialists has been established effective October 1, 1985, to respond to physician and supplier inquiries. The telephone number for this service will be ***(904)-634-4988***. Providers in the local Jacksonville area should also use the new number rather than (904)-355-3670 which will be reserved for beneficiary use.

Blue Cross and Blue Shield of Florida will provide timely and accurate telephone service to the Provider Community on the new toll lines. Your cooperation in using this new telephone number is greatly appreciated.

HFCA 1500 FORMS

We have recently been notified by the Health Care Financing Administration that they will no longer provide or pay for providing HFCA 1500 forms to carriers or users of the forms. We have been instructed to inform you that you may purchase the claim forms on the open market.

The standard version of the HFCA 1500 will be available for direct purchase through private printers or the following:

1. Government Printing Office (GPO)
   Room C836, Building 3
   Washington, D.C. 20401
   (Request in writing)
   GPO sells negative and reproducibles of HFCA 1500.

2. Superintendent of Documents
   U.S. Government Printing Office
   Washington, D.C. 20402
   (202) 783-3283 (pricing desk)
   The Superintendent of Documents will sell form HFCA 1500.
3. American Medical Association (AMA)
   P. O. Box 10946
   Chicago, Illinois 60610
   The American Medical Association sells form HFCA 1500.

Our current supply will soon be depleted; therefore, we suggest you contact the above as soon as possible if your form volume is low.

We are currently studying the feasibility of providing the HFCA 1500 forms at cost to Florida providers. We will be advising you about this at a later date.

Blue Cross and Blue Shield of Florida, Inc.
P. O. Box 41109
Jacksonville, FL 32203

Address correction requested

FIRST CLASS MAIL
U.S. POSTAGE
PAID
PERMIT NO. [illegible]

FIRST CLASS MAIL

Chairman **Heinz**. Well, in view of the testimony by witnesses, what the Department of Health and Human Services is doing and the Health Care Financing Administration is they are spending a lot of time and attention—they are writing bulletins about how to introduce free market principles into the payment and distribution of forms. Meanwhile, they are oblivious—they have their heads in the sand—as to what the bulletins may be doing to cause pain and suffering among Medicare beneficiaries. And that is frankly, if I can be charitable, standing priorities on their head.

Senator Chiles, I thank you for some outstanding examples. This is an outstanding example of——

Senator **Chiles**. Well, I think it tells us why the DRG's are not working, really—not that we did not have to do something for cost containment, but that we have got an agency that is more concerned with trivia like this, than trying to find out what do we do about hospitals that try to discharge patients prematurely. Do we need to put an escape clause in where the days simply are not enough, so that there is a way of trying to provide additional time. I guess it does give us an example of the mindset that is working over there.

Chairman **Heinz**. Absolutely.

Before we conclude, I just want to run through very quickly, in maybe 60 seconds, with Dr. Thomas, a couple of questions I have about your story so that we really have these facts straight, because I found your example just as dramatic, in many ways more so, because your mother was absolutely alone in all this.

As I understand it—and tell me if I am right—your mother was so bruised that she could not walk, and she had head injuries; is that right?

Dr. **Thomas**. That is correct, Senator.

Chairman **Heinz**. She was then, at that point, living alone in a two-story building; is that right?

Dr. **Thomas**. That is correct.

Chairman **Heinz**. And someone drove her to the building, but because there was nobody strong enough to take her up the stairs, because she was so unable to help herself, she had to sit in the car for an hour until someone strong enough to help her into her house came along; is that right?

Dr. **Thomas**. That is correct.

Chairman **Heinz**. And then in the house, according to the directions she received from the hospital, she was supposed to wake herself up every 2 hours and also find a way to apply icepacks, even though she could not get to the refrigerator; is that right?

Dr. **Thomas**. Yes. They are generic instructions, Senator, that say "The patient is to be awakened every two hours," but because she is alone——.

Chairman **Heinz**. I understand, I understand. And I presume that had she been unable to awaken herself, that she was then immediately to phone or get to the hospital; is that correct?

Dr. **Thomas**. That is correct—back down the stairs, into the nonexistent car, and back to the hospital.

Chairman **Heinz**. Was she ever asked whether she did live alone?

Dr. **Thomas**. No, sir.

Chairman HEINZ. Was she ever asked or told that she was going to need any help, such as a wheelchair?

Dr. THOMAS. No, sir.

Chairman HEINZ. Was she led to believe that she could not stay in the hospital for observation?

Dr. THOMAS. She was told specifically that she could not be admitted to the hospital because Medicare would not cover observation.

Chairman HEINZ. Was she led to believe that she could not be there even if she paid for it herself?

Dr. THOMAS. The fact that that could occur did not seem to be a possibility; it did not occur to the physicians nor to any of the other employees of the emergency room. She was not asked whether she had any other medical coverage, nor was she asked whether she would be willing to pay herself.

Chairman HEINZ. Well, Dr. Thomas, I think your answers to those questions make clear that we have a system that is insensitive; we have a system that risks people's lives currently as it is being administered. And we apparently also have people as distantly as Washington, DC, who are supposed to ensure that we do have quality health care under Medicare, but who do not care. This is our second hearing on subjects related to DRG and the quality of care under Medicare; and, again, we are showing that there are people in the administration who maintain what I would charitably call the silence of a graveyard. And they may very well be sending people there.

So I want to thank you very much for your testimony.

Dr. THOMAS. Thank you.

Chairman HEINZ. And I thank Ms. McDonough, Ms. Adair, and Mrs. Bell.

I would be happy to recognize Senator Glenn.

Senator GLENN. Just for a very short statement. I think one thing that has come out here this morning that I want to emphasize is Mrs. Bell's remark about living in a fantasy world about what their health coverages were. Here are people who had HMO coverage, had extended insurance, and had Medicare. I can see how you thought you were pretty well covered.

Mrs. BELL. Yes. I thought that if a catastrophic thing happened that we would get reasonable care—I was not asking for something extraordinary. And that was our contention right along.

One quick comment, if I may, on the insensitivity that Senator Heinz mentioned. I found that to prevail in our HMO. Honestly, when they sent him back to me, home, I got the feeling he was being handled like a piece of meat—and that is a horrible thing to say, but that is exactly what came to my mind, that he was just a thing. Talk about insensitivity.

Senator GLENN. We do not have a full-blown national health insurance program. All costs are not covered, and we know that. People have to make some of their own arrangements, and so we have HMO's and these other options.

But certainly, the people administering these programs can use some sort of judgment on their own, I think. I would encourage them to do so when they see a case like yours and like your husband's; that they do not just go by rote, do not just look at paragraph sub C, 42(x), or whatever it is, and say, "No; I have got to turn him away." There are places to save money in these programs, and there are places where we need to show a little judgment, compassion, and human concern. I do not think anybody wants us to cut back on cases like that, and I do not know how we get that word down to HHS and all of the other entities of Government. Somewhere, there has to be some judgment that there are differences in cases. And as you said, you were living in a fantasy world—you are strapped and you thought you were covered—and that is what too many people are doing.

Mr. Chairman, maybe what we need are some things being put out about what is not covered. We all take great pride in the great Government programs that we pass here, and the manna that flows from Washington and all that sort of business. We are very proud of saying what is covered, but maybe what we need is something about what is not covered, so people know what problems they can run into. Mrs. Bell, if you had known that your HMO did not cover these things, if you had known that Medicare was not going to cover some of these things, maybe there would have been other ways to take care of this.

But we could discuss that all day, and I know we have other panelists.

Thank you, Mr. Chairman.

Mrs. BELL. May I say one thing, Senator Glenn? I think what frightens the nursing homes—and this comment was made to me by the social worker—is the points held against them. There is a margin of error, I understand, of 5 percent or something in our State, and I guess if they exceed that margin of error, there are points or something held against them. I do not quite understand it, but I am sure you folks do.

Senator GLENN. No, I am sure we do not.

Mrs. BELL. Oh. But they were so fearful of keeping an individual on, even for an extra day or whatever; even though in their hearts, they think they should be kept on, they are not, because of this fiscal intermediary point system against the nursing home.

And she just happened to comment—I do not know anything about it other than what she said to me, that points would be held against them.

Senator GLENN. Thank you, Mrs. Bell. Mr. Chairman, I have a conflicting meeting and I have to be gone for a little while. I hope to be back before the next panel completes its testimony, so I can be involved in questioning them, also. I am sorry I have to be away for a little while.

Chairman HEINZ. Senator Glenn, thank you.

Let me thank all four of you for extraordinarily helpful testimony and really genuine citizen heroism in coming here in some cases, from very distant places, to testify before the committee. I think you have performed an invaluable public service, and I want to thank each and every one of you.

Thank you very, very much.

I would like to ask our next group of witnesses to please come forward. I am pleased to welcome to Washington five individuals who every day deliver nursing and medical care and support to the sick and disabled among Medicare beneficiaries.

The reason we have this panel is we need the advice of these witnesses to know if Medicare policies are serving the purpose of ensuring that beneficiaries have access to high-quality health care. The experience of our previous panel of witnesses suggests very much the contrary.

So I am pleased to welcome our witnesses. Our first witness is Ms. Bonna Cornett, a hospital discharge planner from Alabama.

Ms. Cornett, please proceed.

STATEMENT OF BONNA CORNETT, BIRMINGHAM, AL, HOSPITAL DISCHARGE PLANNER

Ms. Cornett. Thank you, Senator.

As a hospital social worker and primary discharge planner for hospital patients, I am faced with many difficult discharge problems. I am often frustrated and concerned for these patients when resources are not available or not adequate enough to meet their needs.

My role in discharge planning is becoming more and more complicated as resources are depleted, funding is cut, and patient caseload increases.

Many times I have no choice but to send a patient home with inadequate resources to meet his needs. When these needs are not met, problems often develop which lead to readmission. If these needs could be met in the home, more patients could receive quality care, and fewer hospitalizations would result.

While I understand and agree with the rationale behind the implementation of the DRG system, I feel it has caused problems in many other areas. The patients are the ones who are really suffering.

The DRG system stresses shorter hospitalization for patients. Therefore, patients are being sent home sicker than they have been in the past. They must depend on family, home health care, or nursing homes to care for them. Many patients do not have any family, or if they do, they are unable to care for their complicated problems. The nursing homes have quickly filled with very skilled care patients and often, there are no beds available. If there is an available bed, the home may have reached their maximum number of skilled patients and cannot care for any more. Because the nursing homes are so full, it sometimes takes weeks or months to place patients. Before, when more beds were available, homes were more willing to take patients without financial sponsors and for the amount of their checks. Now, very few will do so.

One of the most difficult problems I face with nursing home placements are those patients who need skilled care in a nursing home but do not qualify for Medicaid coverage after the Medicare days are used. Without Medicaid coverage, a patient must return home with home health care to follow. Their needs are often too great for home health care to handle due to limited visits during daytime hours only.

My concern is for these elderly patients who cannot be placed in nursing homes, who even with home health care cannot continue to live at home. What is to become of them?

Another problem area is patients who are ventilator dependent. Medicare covers part of this expense at home, but a great deal of the supplies and services required are not covered. Most families cannot afford all the expense. Many times, the families cannot handle the 24-hour care that is required for ventilator patients. Nursing home placement is almost impossible because the homes do not have the equipment nor the expertise required. A few homes are beginning to accept them, but the family must pay for the equipment and supplies, often a fulltime R.N., plus the cost of the nursing home. If the family can afford the extra expenses, they probably do not qualify for Medicaid. This means about $3,000 per month total expense in a nursing home. Since very few families can afford this, most patients remain in the hospital because there are no alternatives available.

Boarding homes are another problem area. There are currently no laws to regulate these homes. However, we are presently working toward this. Many boarding homes are inadequate, and patients are sometimes neglected. Home health care agencies and other community agencies try to monitor patients' care, but often they are not aware of the problem until it is too late.

Most of the patients that I refer to are the elderly population, over the age of 65—the fastest growing population in the country. We must plan now for these growing problems and concerns. More consideration needs to be given to their social problems and family situations. I am not asking for massive welfare programs, but only that we as concerned citizens take a look at the growing needs of the elderly population to provide them with quality health care and quality of life. Thank you.

Chairman HEINZ. Thank you very, very much, Ms. Cornett.

Our next witness is Mr. John Rutoskey, the administrator of a skilled nursing facility in Birmingham, AL.

Mr. Rutoskey?

STATEMENT OF JOHN MITCHELL RUTOSKEY, BIRMINGHAM, AL, SKILLED NURSING HOME ADMINISTRATOR

Mr. RUTOSKEY. Thank you, Mr. Chairman.

My name is John Mitchell Rutoskey, administrator of a 113-bed, dual-certified, skilled and intermediate care facility in Birmingham, AL.

The prospective payment system has created a dramatic change in hospital and posthospital care. The patients that are discharged to nursing homes, boarding homes, or directly to home in care of a home health agency, are much sicker than those patients in the past.

The entire reimbursement system for hospital care has changed, but nothing has been done to improve the reimbursement mechanism for a Medicare patient in the nursing home.

There are three areas in the existing Medicare reimbursement mechanism that are hampering utilization in the existing program, as well as expansion of the program to other nursing homes throughout the country.

These areas are: One the cost reporting mechanism is too complex. It requires unnecessary paperwork and undue reporting requirements in order to receive reimbursement.

As a result of the complexity of the cost reporting system, the nursing homes who choose to participate in the Medicare Program do not really know at what rate they will be reimbursed for their services. Currently, a facility who participates in Medicare will have a cost increase due to the type of patient that is being discharged from the hospital and will not know what their reimbursement rate is until after they have filed a cost report and settled with the Medicare intermediary.

Third, the issue of the Medicare waiver of liability, which Mrs. Bell talked about earlier, which was a part of the Social Security Amendments of 1972, section 213(a) specifically. The waiver of liability protects a provider of services who accepts the Medicare patient in good faith and delivers his services, but finds out later that their cost was not reasonable or that they provided what might be considered custodial care.

When determining a provider's liability, a favorable presumption is given to a provider who demonstrates their ability to distinguish between covered and noncovered items. This favorable presumption is necessary in order for providers to be willing to enter into the Medicare Program. This waiver liability is 5 percent of your total Medicare days in the facility.

We strongly request that Congress place the waiver of liability into a permanent status.

A waterfall effect has been created by the changing health care delivery system. Since the hospitals have been discharging patients much earlier, the levels of care in nursing homes has also changed. The nursing homes are increasing their standard of care and staffing to a subacute level.

There is an ever-growing population of geriatric patients who need nursing home care, but since the beds are being taken by the sicker and more acute patient who is being discharged from the hospital, a void is being created.

These chronic care patients are being forced into boarding homes or back home. Thus, the waterfall effect begins to have a very sad and profound impact on the lives of people who can no longer care for themselves.

In the mid-sixties through the late seventies, the type of patient being placed in the nursing home did not require the medical care that the industry is experiencing today. Also, a tremendous controversy concerning the care received by the geriatric patient in the nursing homes arose and resulted in the industry becoming the most regulated body in the health care delivery system. The patients with the same diagnosis that we saw in the mid-sixties and seventies are now being forced to receive these services from a very unregulated source, the boarding homes.

In addressing the entire problem of our health care delivery system involving the ever-growing geriatric population, we cannot limit our vision to the one area of the prospective payment system. If we do so, we are creating a much greater problem. The cycle begins when the acutely ill patient enters the hospital and is discharged in a much sicker condition because of the DRG's, to the nursing home. This increases the utilization of nursing home beds, which forces social workers to seek placement of chronic care patients to other areas which are not regulated—again, boarding homes, or even back home. Those patients who are admitted to the boarding home do not receive the day-to-day nursing care which usually results in deterioration of their condition. There is an increase in further illnesses such as decubitis, fractures, dehydration, malnutrition and other similar situations, thus the never-ending cycle of the waterfall effect.

We mentioned earlier one way to enhance and improve on the Medicare Program would be related to the reimbursement mechanism. In this segment, we see a way to improve on the delivery system by developing a planning mechanism for meeting the needs of the geriatric patient.

There is an access problem for the chronically ill patient who needs some form of nursing home care. This has been created by the following causes.

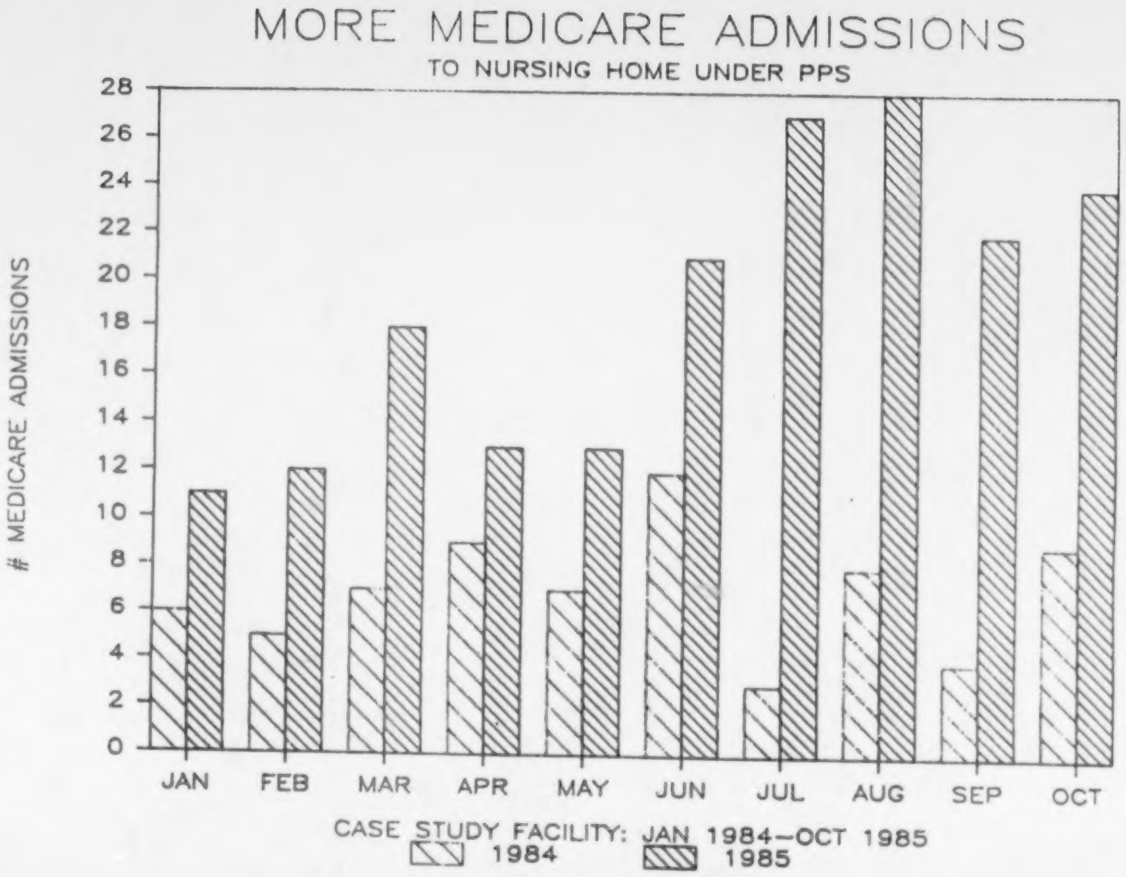
In a large number of States, nursing home beds that used to be available for the chronically ill patient have been taken over by the acutely ill patient.

Second, in many States, this bed need shortage is recognized and supported by high occupancy figures but the Medicaid agencies, due to State budgetary problems, have placed moratoriums on creation of new beds or new facilities in the States.

This lack of bed availability is beginning to have a serious impact on the acutely ill patient as well as the chronically ill patient in many States. The initial impact of the discharge from hospitals as a result of DRG's has not been absorbed in most States and is continuing to necessitate numerous patients to be admitted to the nursing homes. This group of patients coupled with the chronically ill patients is creating a serious problem for the existing health care delivery system.

If you would look at the first chart, I would like to show some comparisons of 1984 to 1985. We have compared the Medicare admissions of 1984 to the Medicare admissions of 1985. As you can see, there is a threefold increase in our Medicare admissions which are high-skilled, subacute care-type patients. This has been a 276-percent increase.

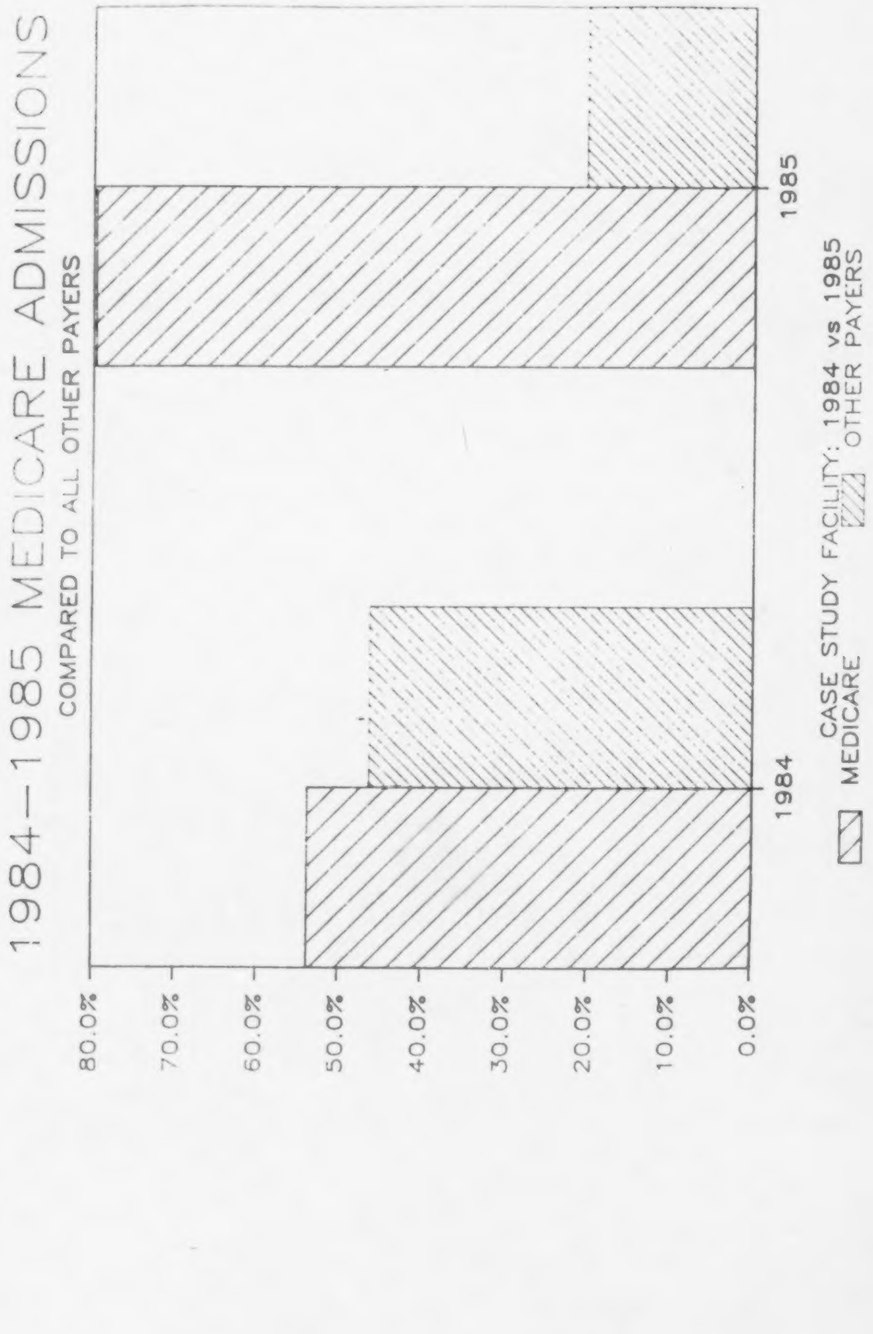
CHART 1



MORE MEDICARE ADMISSIONS

TO NURSING HOME UNDER PPS

CHART 2


1984—1985 MEDICARE ADMISSIONS
COMPARED TO ALL OTHER PAYERS
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
1984
1985
CASE STUDY FACILITY: 1984 vs 1985
MEDICARE
OTHER PAYERS

To show how important this point is, please look at the second graph. This graph shows the percentage of increase of Medicare admissions to overall admissions. As you can see, we have an increase, an average increase of 55 percent Medicare admissions to a skyrocketing 80 percent of all admissions. We have just had a complete turnaround.

The percentage that is left, the average 20 percent that is left, is divided among VA patients, private pay patients, skilled patients without Medicare, and ICF patients.

The Medicare admissions include patients who are heavy care, ventilator-dependent, oxygen-dependent, need tube feedings, I.V. therapy, Clinitron therapy, speech therapy, physical therapy, and have trachostomies, and the list goes on.

A facility has to gear its staff according to the needs of these patients. No longer are minimal State staffing requirements in line with the trend that PPS has put on the industry. Many facilities cannot increase their staffing when State agencies put a cap on reimbursement in line with minimal staffing requirements. The PPS has antiquated the current system of reimbursement to nursing homes with no relief in sight.

And finally, staffing, which requires more money, has to be increased. The increased coverage includes full-time R.N. staffing 24 hours per day. Staffing has to be increased also in the area of LPN's and aides. There are very few nursing homes that will be able to accomplish this increase in staffing and stay solvent.

We need to address the entire problem of the health care delivery system of the geriatric patient and not just the initial step, which is the hospital stay and the prospective payment system, if we want to improve the quality of life and care for the elderly. Thank you.

Chairman HEINZ. Mr. Rutoskey, thank you very much.

[The prepared statement of Mr. Rutoskey follows:]

PREPARED STATEMENT OF JOHN MITCHELL RUTOSKEY

This is the testimony of John Mitchell Rutoskey, Administrator of a one-hundred thirteen (113) bed dual-certified, skilled and intermediate care facility in Birmingham, Alabama on October 24, 1985 to the Special Committee on Aging, United States Senate.

The perspective payment system has created a dramatic change in hospital and post hospital care. The patients that are discharged to nursing homes, to a boarding home or directly to home are much sicker than those patients in the past. The entire reimbursement system for hospital care has changed but nothing has been done to improve the reimbursement mechanism for a medicare patient in the nursing home.

There are three (3) areas in the existing medicare reimbursement mechanism that are hampering utilization in the existing program as well as expansion of the program to other nursing homes throughout the country. These areas are:

I. The cost reporting mechanism is too complex. It requires unnecessary paper work and undue reporting requirements in order to receive reimbursement.

II. As a result of the complexity of the cost reporting system the nursing homes who choose to participate in the medicare program do not really know at what rate they will be reimbursed for their services. Currently a facility who participates in medicare will have a cost increase due to the type of patient that is being discharged from the hospital and will not know what their reimbursement rate is until after they have filed a cost report and settled with the medicare intermediary.

III. The issue of the medicare waiver of liability which was part of the social security amendments of 1972 Section 213 (a) specifically. The waiver of liability protects a provider of services who accepts the medicare patient in good faith and delivers his services but finds out later that their cost was not reasonable or that they provided what might be considered custodial care. When determining a providers liability a favorable presumption is given to a provider who demonstrates their ability to distinguish between covered and non-covered items. This favorable presumption is necessary in order for providers to be willing to enter into the medicare program. We strongly request that Congress place the waiver of liability into a permanent status.

A waterfall effect has been created by the changing health care delivery system. Since the hospitals have been discharging patients much earlier the levels of care in nursing homes has also changed. The nursing homes are increasing their standard of care and staffing to a sub-acute level.

There is an every growing population of geriatric patients that need nursing home care but since the beds are being taken by the sicker, and more acute patient which is being discharged from the hospital, a void is being created. There chronic care patients are being forced into boarding homes. Thus the waterfall effect begins to have a very sad and profound impact on the lives of people who can no longer care for themselves.

In the mid 60's and through the late 70's, the type of patient being placed in the nursing home did not require the medical care that the industry is experiencing today. Also, a tremendous controversy concerning the care received by the geriatric patient in the nursing homes arose and resulted in the industry becoming the most regulated body in the health care delivery system. The patients with the same diagnosis that we saw in the mid 60's and 70's are now being forced to receive services from a very unregulated source, *the boarding homes.*

In addressing the entire problem of our health care delivery system involving the ever growing geriatric population, we cannot limit our vision to the one area of PPS, if we do so we are creating a much greater problem. The cycle begins when the acutely ill patient enters the hospital and is discharged in a much sicker condition (because of DRG's) to the nursing home. This increases the utilization of nursing home beds which forces social workers to seek placement of chronic care patients to other areas which are not regulated; the boarding home. These patients who are admitted to the boarding home do not receive the day to day nursing care which usually results in deterioration of their condition. There is an increase in further illnesses such as decubitis, fractures, dehydration, malnutrition and other similar situations, thus the never ending cycle of the waterfall effect.

We mentioned earlier one way to enhance and improve on the medicare program would be related to the reimbursement mechanism. In this segment we see a way to improve on the delivery system by developing a planning mechanism for meeting the needs of the geriatric patient. There is an access problem for the chronically ill patient who needs some form of nursing home care. This has been created by the following causes:

I. In a large number of states nursing home beds that used to be available for the chronically ill patient have been taken over by the acutely ill patient.

II. In many states this bed need shortage is recognized and supported by high occupancy figures but the medicaid agencies because of state budgetary problems have moratoriums on creation of new beds or new facilities in the states.

III. This lack of bed availability is beginning to have a serious impact on the acutely ill patient as well as the chronically ill patient in many states. The initial impact of the discharge from hospitals as a result of DRG's has not been absorbed in most states and is continuing to necessitate numerous patients be admitted to the nursing home. This group of patients coupled with the chronic ill patients is creating a serious problem for the existing heath care delivery system. There is a recognition of the role of the hospital swing bed program but this is only a stop-gap method to the real problem.

If you would look at the Bar graph labeled "Graph #1" I would like to show some comparisons of 1984 to 1985. We have compared the medicare admissions of 1984 to the medicare admissions of 1985. As you can see, there is a three fold increase in our medicare admissions which are your high skilled, sub-acute care type patients. This has been a 276 percent increase. To show how important this point is, please look at Graph #2. This graph shows the percentage of increase of medicare admissions to overall admissions. What we see, is an increase of medicare admissions to overall admissions. What we see, is an increase of medicare admissions of 33% to a skyrocketing 85% of all admissions. The 15% that is left is divided among VA patients, private pay patients, skilled patients without medicare and ICF patients.

The medicare admissions include patients who are heavy care, ventilator dependent, oxygen dependent, need tube feedings, I.V. therapy, Clinitron therapy, Speech therapy, Physical therapy, and have trachostomies and the list goes on. A facility has to gear their staff according to the needs to these patients. No longer are minimal state staffing requirements in line with the trend that PPS has put on the industry. Many facilities can not increase their staffing when state agencies put a cap on reimbursement in line with minimal staffing requirements. The PPS has antiquated the current system of reimbursement to nursing homes with no relief in sight.

Staffing, which requires more money, has to be increased. The increased coverage incudes full time RN staffing 24 hours per day. Staffing has to be increased, also, in the area of LPN's and Aides. There are very few nursing homes that will be able to accomplish this increase in staffing and stay solvent.

This puts the nursing home in a Catch 22, the face insolvency if they increase staffing and admit these skilled patients or face insolvency if they don't increase staffing and don't admit these type patients. Also, the State of Alabama has passed more stringent medical requirements, in the past 3 years on the eligibility pre-requisites for a potential Medicaid, ICF or Skilled patient. The alternative to the industry is to admit the medicare and skilled patients and not increase staffing because of the reimbursement mechanism. This alternative will force the industry to forfeit quality care and revert to the times of a decade past.

We need to address the entire problem of health care delivery system of the geriatric patient and not just the initial step which is the hospital stay if we want to improve the quality of life and care for the elderly.

CHART 1

Nursing home beds based on lower of state-specific usage rates or U.S. average for the over 85 population

State	Nursing home beds in 1980	Increase in beds by: 1990	Increase in beds by: 2000	Percent increase from 1980-2000
Alabama	20,650	11,723	29,155	141
Alaska	1,028	340	2,119	206
Arizona	9,308	15,297	45,002	483
Arkansas	19,237	6,218	17,987	94
California	163,481	70,679	191,043	117
Colorado	17,309	6,503	17,999	104
Connecticut	21,243	9,998	23,625	111
Delaware	2,529	2,053	4,870	193
District of Columbia	3,179	-298	-198	-6
Florida	36,121	34,828	94,990	263
Georgia	30,040	17,996	50,294	167
Hawaii	2,804	3,006	5,961	213
Idaho	4,354	1,536	4,714	108
Illinois	88,382	23,223	61,335	69
Indiana	44,510	12,421	36,508	82
Iowa	34,640	2,447	10,111	29
Kansas	25,207	2,711	9,485	38
Kentucky	26,264	11,371	28,272	108
Louisiana	21,671	14,595	34,168	158
Maine	11,316	2,648	7,980	71
Maryland	20,725	16,460	37,903	183
Massachusetts	52,253	17,543	38,003	73
Michigan	80,081	2,442	35,630	44
Minnesota	41,940	3,574	14,933	36
Mississippi	12,252	6,362	14,913	122
Missouri	46,690	10,515	28,854	62
Montana	5,651	1,542	4,625	82
Nebraska	18,989	581	4,687	25
Nevada	2,021	5,392	19,378	959
New Hampshire	6,671	3,798	8,930	134
New Jersey	37,824	21,585	47,779	126
New Mexico	3,074	3,390	9,051	294
New York	103,951	42,465	76,577	74
North Carolina	32,172	26,744	69,238	215
North Dakota	6,449	123	1,830	28
Ohio	76,279	34,916	81,035	106
Oklahoma	27,100	7,796	22,920	85
Oregon	17,381	8,691	22,830	131
Pennsylvania	75,906	41,866	93,541	123
Rhode Island	8,652	3,655	8,318	96
South Carolina	11,989	11,151	29,556	247
South Dakota	8,646	44	1,755	20
Tennessee	21,691	13,309	32,329	149
Texas	101,327	25,196	96,018	95
Utah	5,051	2,158	5,847	116
Vermont	4,705	1,385	3,506	75
Virginia	27,376	18,185	44,363	162
Washington	39,152	2,657	24,828	63
West Virginia	6,422	4,205	9,370	146
Wisconsin	49,846	1,953	19,266	39
Wyoming	1,758	754	1,759	100
Total U.S.	1,537,288	589,963	1,584,994	103

Source: Nursing home bed data from unpublished estimates of the Master Facility Index provided by NCHS: population data from U.S. Bureau of the Census, Population Estimates and Projections, Series P-25, No. 937, 1983.

CHART 2

STATE	POPULATION 65 AND OLDER 1982	PERCENT OF STATE POPULATION 65 AND OLDER 1982	PERCENT OF NATIONAL POPULATION 65 AND OLDER 1982	PERCENT GROWTH IN 65 AND OLDER 1970-1982
Alabama	461,000	11.7	1.7	42.0
Alaska	13,000	2.9	.05	85.0
Arizona	341,000	11.8	1.2	112.0
Arkansas	324,000	14.0	1.2	37.0
California	2,554,000	10.3	9.5	37.0
Colorado	263,000	8.7	1.0	41.0
Connecticut	387,000	12.4	1.5	34.0
Delaware	63,000	10.5	0.2	43.0
Dist. Columbia	74,000	11.8	0.3	6.0
Florida	1,812,000	17.3	6.7	84.0
Georgia	549,000	9.7	2.1	50.0
Hawaii	85,000	8.6	0.3	93.0
Idaho	101,000	10.3	0.4	51.0
Illinois	1,311,000	11.4	4.9	20.0
Indiana	613,000	11.2	4.9	25.0
Iowa	400,000	13.8	1.5	15.0
Kansas	315,000	13.1	1.2	19.0
Kentucky	425,000	11.5	1.6	26.0
Louisiana	419,000	9.6	1.6	37.0
Maine	147,000	12.9	0.6	29.0
Maryland	422,000	9.9	1.6	42.0
Massachusetts	752,000	13.1	2.8	19.0
Michigan	962,000	10.6	3.6	28.0
Minnesota	500,000	12.1	1.9	28.0
Mississippi	299,000	11.6	1.1	35.0
Missouri	666,000	13.5	2.5	19.0
Montana	90,000	11.2	0.3	32.0
Nebraska	211,000	13.3	0.8	15.0
Nevada	77,000	8.8	0.3	148.0
New Hampshire	109,000	11.5	0.4	40.0
New Jersey	902,000	12.1	3.4	30.0
New Mexico	126,000	9.2	0.5	80.0
New York	2,203,000	12.5	8.2	12.0
North Carolina	648,000	10.8	2.4	57.0
North Dakota	84,000	12.5	0.3	27.0
Ohio	1,225,000	11.4	4.6	23.0
Oklahoma	389,000	12.1	1.5	30.0
Oregon	324,000	12.1	1.2	43.0
Pennsylvania	1,605,000	13.5	6.0	27.0
Rhode Island	132,000	13.8	0.5	27.0
South Carolina	310,000	9.7	1.2	63.0
South Dakota	94,000	13.5	0.4	18.0
Tennessee	543,000	11.7	2.0	42.0
Texas	1,441,000	9.4	5.4	46.0
Utah	118,000	7.5	0.4	53.0
Vermont	61,000	11.7	0.2	30.0
Virginia	538,000	9.8	2.0	48.0
Washington	462,000	10.8	1.7	44.0
West Virginia	247,000	12.6	0.9	27.0
Wisconsin	590,000	12.4	2.2	26.0
Wyoming	39,000	7.7	0.2	30.0

Source: Bureau of the Census, U.S. Department of Commerce

Chairman HEINZ. It is now with some pleasure that I have the opportunity to introduce two of my constituents from Pennsylvania. For a while, I was worried than Senator Grassley and Senator Glenn were going to have all of the constituents, but I saw Bob Stutz sitting out there calmly in the audience.

Mr. Stutz is the vice president of the Albert Einstein Medical Center in Philadelphia, PA, and he is accompanied by Dr. Raymond Cogen, who is the medical director of the Willowcrest-Bamberger Division, which is the skilled nursing home of the Albert Einstein Medical Center.

Bob, Dr. Cogen, it is a great pleasure to have both of you here, and we welcome you to the committee. Please proceed, Dr. Cogen.

STATEMENT OF DR. RAYMOND COGEN, MEDICAL DIRECTOR, ALBERT EINSTEIN MEDICAL CENTER, WILLOWCREST-BAMBERGER DIVISION, PHILADELPHIA, PA

Dr. COGEN. Thank you, Senator.

Willowcrest is a nonprofit skilled nursing facility that provides rehabilitative and nursing services to recently hospitalized patients, with the goal of returning the patient to the community. We are a short-stay facility with an average length of stay of 18 days.

Over the past 12 months, we have noticed a drastic change in the way the Health Care Financing Administration and our Medicare intermediary are interpreting Medicare regulations, regarding what is and what is not skilled care.

One year ago, less than 5 percent of the services we provided did not meet the skilled level of care. This year, our intermediary has denied as much as 60 percent of the inpatient days for which we have sought reimbursement.

In an attempt to comply with regulations, we have been forced to deny admission to many patients who we feel truly require skilled care services. Approximately 100 hospital patients are denied admission each month. Our daily inpatient census has fallen from approximately 100 to a current low of 35.

I would like to discuss some of the services we have traditionally provided for which we no longer receive reimbursement.

HCFA and our Medicare intermediary have adopted an extremely narrow viewpoint as to what is skilled nursing. They apparently believe that the skill of nursing lies in the performance of technical tasks, such as changing a dressing, inserting a catheter or feeding a patient through a nasogastric tube. If a patient is not receiving such a service, our Medicare intermediary will deny payment for that stay.

In fact, most people can be trained to perform these tasks within a few weeks. A 2- or 4-year nursing degree is not required. The real skill of nursing lies in the ability to observe and monitor a patient's physical condition, the cardiovascular function, the pulmonary function, the hydration status, and to assess the patient's medical needs and his response to therapy.

Interestingly, Medicare regulations do allow for skilled observation and monitoring of unstable medical conditions. Unfortunately, however, the rigid interpretation of HCFA directives by our Medicare intermediary has essentially removed observation and monitoring as a skilled service.

Let me give you an example. Recently, we admitted an elderly man who had undergone a major operation for cancer. He stayed at Willowcrest for 1 week, during which time he developed diarrhea, fever, a markedly abnormal and dangerous heart rhythm, and became progressively dehydrated, necessitating his transfer back to the acute care hospital. Our nurses were monitoring his input and output of fluids, his temperature, his heart rate, and his general condition at least three times a day and more often on most days. He required several emergency visits from the house physician, who ordered stat electrocardiograms and changes in his medication. Our Medicare intermediary reviewed the chart and decided that he had received no skilled service.

There were no N/G tubes or decubitus ulcers, and therefore, in their minds, the nursing was not skilled. I wonder whether a representative from the American Nursing Association would agree with their judgment.

Akin to skilled observation and monitoring is the provision of physical therapy and rehabilitation services to patients who have become deconditioned during extended hospital stays for medical or surgical problems. It is well-recognized by geriatricians that many elderly patients kept at bedrest soon develop significant physical deterioration.

In attempting to get these patients back on their feet, great skill and care is required in order to recondition muscles, restore balance, and prevent precipitous drops in blood pressure.

Unfortunately, HCFA and our Medicare intermediary have determined that this process does not require skilled personnel and suggests that these patients be discharged home. The intermediary points out that physical therapists from home health agencies can assist family members, who are often eldery themselves. However, visiting physical therapists in Philadelphia rarely can come to the home more than three times a week. This greatly prolongs the recovery time for these patients, putting them at risk for such complications as pneumonia, pressure sores, and phlebitis. In contrast, a skilled nursing facility can provide physical therapy two times a day, 6 days a week, assuring prompt recovery.

During the preceding year, we were informed that a very important physical therapy service is no longer considered skilled care. I am referring to the teaching of transferring techniques. Simply defined, "transferring" is the ability to get oneself from the bed into a chair. Although this may seem trivial, it often is a skill that provides the difference between a return home or placement in a long-term care facility.

Our Medicare intermediary has stated that the teaching of transferring is not a justifiable reason to be at Willowcrest.

There are other services that our intermediary has told us we will not be reimbursed for. As a hospital—based skilled nursing facility, radiation therapy is available in an adjacent building. We have traditionally admitted severely compromised cancer patients to Willowcrest while they received radiation therapy. Medicare recently refused payment for one such patient—an elderly woman with breast cancer that had spread to her spine. This woman's weight had dropped to 60 pounds; she could not walk, and she was in considerable pain, requiring high dosages of narcotics. Despite her condition, Medicare decided that she should have received her therapy as an outpatient, taking an uncomfortable and exhausting ambulance ride twice a day.

Finally, HCFA and our Medicare intermediary tell us that when deciding on the appropriateness of a stay in a skilled nursing facility, the patient's social situation is not to be considered. Medicare will pay us for a patient with a hip fracture until that patient can use a walker with the physical therapist's hand for support. We ask how can we discharge such a patient to home if they still require the therapist's hand to walk safely.

Often, we must keep a patient an additional week or two until safely independent, even though we know we will not be reimbursed. This is especially true when the patient lives alone and has no available family or funds to hire an assistant. As care providers, we cannot send a patient home in an unsafe condition.

In summary, the changes in the way Medicare regulations are being interpreted have greatly hampered our ability to provide skilled care. Doctors are frustrated and extremely angry over our inability to admit patients who they believe need skilled care.

We have had to close one-half of our facility, forcing us to deny an important service to our elderly community.

Thank you for allowing me to speak before this committee.

[The prepared statement of Dr. Cogen follows:]

PREPARED STATEMENT OF DR. RAYMOND COGEN

My name is Dr. Raymond Cogen. I am the Medical Director of the Willowcrest-Bamberger Division of Albert Einstein Medical Center in Philadelphia. Willowcrest is a non-profit, skilled nursing facility that provides rehabilitative and nursing services to recently hospitalized patients with the goal of returning the patient to the community. We are a short stay facility with an average length of stay of 18 days.

Over the past twelve months, we have noticed a drastic change in the way the Health Care Financing Administration [HCFA] and our Medicare intermediary are interpreting Medicare regulations, regarding what is and what is not skilled care. One year ago, we had a liability waiver, meaning that less than 5 percent of the services we provided did not meet the skilled level of care. This year, our intermediary has denied as much as 60 percent of the inpatient days we have sought reimbursement for. In an attempt to comply with regulations, we have been forced to deny admission to many patients who we feel truly require skilled care services. Our daily inpatient census has fallen from approximately 100 to a current low of 35. It is ironic that this change in HCFA has occurred at a time when patients seeking admission appear sicker than in the past. We are forced to refuse admission to between 80 and 100 hospital patients per month.

I would like to discuss some of the services we have traditionally provided for which we no longer receive reimbursement.

1. HCFA and our Medicare intermediary have adopted an extremely narrow viewpoint as to what is skilled nursing. They apparently believe that the skill of nursing lies in the performance of technical tasks, such as changing a dressing, inserting a catheter or feeding a patient through a nasogastric tube. If a patient is not receiving such a service, our Medicare intermediary will deny payment for that stay.

In fact, these technical procedures do not require a two or four year nursing degree. The skill of nursing lies in the ability to observe and monitor a patient's physical condition, his cardiovascular function, his pulmonary function, his hydration status, and to assess the patient's medical needs and his response to therapy.

Interestingly, Medicare regulations do allow for skilled observation and monitoring of unstable radical conditions. In Pennsylvania, both the Skilled Nursing Manual published by Medicaid and the Peer Review Organization (KePRO) Manual consider observation and monitoring to be a skilled nursing service.

Unfortunately, however, the rigid interpretation of HCFA directions by our Medicare intermediary has essentially removed observation and monitoring as a skilled service. Let me give you an example: Recently we admitted an elderly man who had undergone a major operation for cancer. He stayed at Willowcrest-Bamberger for one week during which time he developed diarrhea, fever, a markedly abnormal and dangerous heart rhythm and became progressively dehydrated, necessitating his transfer back to the acute care hospital. Our nurses were monitoring his input and output of fluids, his temperature, his heart rate and his general condition at least three times a day and more often on most days. He required several emergency visits from the house physician who ordered stat electrocardiograms and changes in his medication. Our Medicare intermediary reviewed the chart and decided that he had received no skilled care.

There were no N/G tubes or decubitus ulcers and, therefore, in their minds the nursing service is not skilled. I wonder whether a representative from one of the National Associations would agree.

2. Akin to skilled observation and monitoring is the provision of physical therapy and rehabilitation services to patients who have become deconditioned during extended hospital stays for serious medical or surgical problems. It is well recognized by geriatricians that many elderly patients kept at bedrest soon develop significant deterioration in their pulmonary, cardiovascular, neurological and muscular functioning. In attempting to get these patients back on their feet, great skill and care is required, both from nurses and physical therapists in order to recondition muscles, restore balance and prevent precipitous drops in blood pressure.

Unfortunately, HCFA and our Medicare intermediary have determined that this process does not require skilled personnel and suggests that these patients be discharged to home where family members can handle the situation. The intermediary points out that physical therapists from Home Health Agencies can assist members of the family who are often elderly themselves. However, visiting physical therapists in Philadelphia rarely can come to the home more than three days a week. This greatly prolongs the recovery time for these patients, putting them at risk for such complications as pneumonia, pressure sores and phlebitis. In contrast, a skilled nursing facility can provide physical therapy two or more times a day, six days a week in order to assure prompt recovery.

While it is true that a vigorous, healthy 73 year old, such as President Reagan, can undergo major surgery and reassume the most important job in the world without an intervening stay at a skilled nursing facility, many elderly are not so fortunate. Many elderly are frail and plagued with multiple medical conditions that make their recovery much more complicated.

3. During the preceding year, we were informed that a very important physical therapy service is no longer considered skilled care. I am referring to the teaching of transferring techniques. Simply defined, transferring is the ability to get onself from a bed into a chair.

Although this may seem trivial, it is one of the most important activities that a human being needs to do. For if one cannot transfer independently or with the minimal assistance of a helper, then institutionalization in a long term care facility, a nursing home, is a very likely outcome. It is very hard for a patient who requires maximal assistance to transfer to be managed in the community.

It is not unusual for a stroke patient to be too greatly impaired to ever walk again. However, with the intensive help of a trained physical therapist, such a patient can learn to transfer from his bed to a wheelchair, thus gaining significant independence, mobility, and the likelihood of returning home.

HCFA and our Medicare intermediary have stated that the teaching of transferring, in itself, is not a justifiable reason to be at Willowcrest-Bamberger.

4. Without getting into great detail, there are other services that our intermediary has told us we will not be reimbursed for. At a hospital-based skilled nursing facility, Radiation Therapy is available in an adjacent building. We have traditionally admitted severely compromised cancer patients to Willowcrest-Bamberger while they receive Radiation Therapy. Medicare recently refused payment for an elderly woman with breast cancer that had spread to her spine, who was at Willowcrest-Bamberger receiving Radiation Therapy. Despite the fact that this woman's weight had dropped to 60 lbs., she could not walk, and was in considerable pain requiring high doses of narcotics, Medicare decided that she should have received her therapy as a outpatient, taking an uncomfortable ambulance ride twice a day.

Our problems at Willowcrest are not limited to the type of patients we can admit. Even when our Medicare intermediary approves an admission they frequently deny payment for several days of the patient's stay. For example, if a patient with a fractured hip who has received physical therapy and is awaiting discharge, complains of chest pain, it is incumbent upon her physician to evaluate her new complaint. Because chest pain is potentially very serious, it is not appropriate to discharge the patient and evaluate the new problem on an outpatient basis. To do so would in fact be malpractice.

Standard practice for the evaluation of chest pain often requires three additional inpatient days. Interestingly, if it turns out that the patient's chest pain is of cardiac origin and the patient is transferred back to the acute care hospital, the Medicare intermediary will pay us. If, on the other hand, careful evaluation leads the physician to believe that the problem is not cardiac and, therefore, not life-threatening, payment is denied. In other words, our doctors need to have precognition and should be able to declare the origin of a medical problem before they evaluate it!

Finally, HCFA and our Medicare intermediary tell us that when deciding on the appropriateness of a stay in a skilled nursing facility, the patient's social situation is not to be considered. This presents great problems. For instance, Medicare will pay us for a patient with a hip fracture until that patient can use a walker with the physical therapist's hand on the patient's back for guidance and support. We ask how can we discharge such a patient to home if they still require the therapist's hand to walk safely? If the patient is going to the home of an adult child, there is no problem; but what if the patient lives alone and has no nearby family, a familiar situation for many elderly? HCFA and the intermediary say, "The home situation does not matter. The patient can hire a companion." However, the expense of such a companion is prohibitive for many of our patients. Medicare shrugs its bureaucratic shoulders. We end up keeping the patient an additional week or two until she is walking independently even though we know we will not be reimbursed. As care providers, we cannot send a patient home in an unsafe condition.

In summary, the changes in the way Medicare regulations are being interpreted have greatly hampered our ability to provide skilled care. Doctors are frustrated and angry over our inability to admit patients who they believe need skilled services. We have had to close one-half of our facility forcing us to deny an important service to our elderly community. The continued existence of our facility is in doubt. The quality of care and of peoples' lives is suffering.

Thank you very much for allowing me to speak before this committee.

Chairman HEINZ. Bob, do you have any comments you would care to add?

STATEMENT OF ROBERT STUTZ, PHILADELPHIA, PA, VICE PRESIDENT, ALBERT EINSTEIN MEDICAL CENTER

Mr. STUTZ. Thank you, Senator, just that I think it is extremely ironic that at a time when we have heard Mrs. Bell's story and others, that people are coming out of the hospitals in great need of skilled care, we happen to have had a facility for many years that provided essentially subacute care, and at a time when this need is great, we are being told we cannot provide the care, and we are refusing and denying many cases such as probably Mrs. Bell's husband might not have gotten into our facility.

One other point I would make that Senator Glenn brought up, and that is the miscommunication of what the benefits are to the elderly population. I think there was a survey recently done by some of the health care associations that showed that about 80 percent of the elderly believe that Medicare covers nursing home stays, when there is no guarantee that Medicare will even cover 1 day of skilled care. It is very difficult to make that judgment as a provider when you are admitting a patient, and the family certainly cannot make that judgment. It is also very difficult for a doctor. Many times, it is almost a situation where you need a crystal ball. Everybody does their best, places the patient where they think the patient needs the care, only to find out several months later that the intermediary or HCFA has decided that this patient did not need the skilled care.

The bottom line is that it is extremely limiting our ability to even accept patients.

In the interest of time I will stop there, but thank you very much.

Chairman HEINZ. I just want to clarify one thing with either you or Dr. Cogen.

We use the term "fiscal intermediary" which is somehow a shadowy creature out there. Immanuel Kant might have described it as "numina lurking behind the phenomena" that if making these decisions.

Would you tell our audience for the record what the relationship between the Health Care Financing Administration, the fiscal intermediary, and yourselves, in fact, is?

Mr. STUTZ. These are agencies such as insurance companies that HCFA contracts with to administer the Medicare Program. There are huge differences that we find between intermediaries in interpreting the Medicare regulations. There are even major differences between the reviewers themselves, sometimes within the same intermediary.

HCFA is sending out the guidelines, and, I think, as someone mentioned before, there are regulations that have come out, have not come through Congress at all, I think are not the intent of Congress in the original Medicare regulations, and these regulations are strictly, I think, aimed at dollar decisions, winding down programs, and this is one that that has happened to. HCFA then passes these memoranda, et cetera, on to the intermediary. They do supposedly monitor their intermediaries. I do not know that there is quality control between the intermediaries; there does not seem to be a great deal of that. And as I say, in our region, we know that there are several intermediaries looking at the same groups of patients and having extremely different interpretation of who and who cannot come through the door of a facility.

Chairman HEINZ. When you think an intermediary is misinterpreting a regulation or a bulletin, do you have any right of appeal?

Mr. STUTZ. The only appeal that the provider has—and I want to emphasize, when we talk about the beneficiaries' rights, many of the beneficiaries sometimes are very frail elderly individuals who are not apprised, and they are not going to go through the process. The provider only has a one-step appeal, and that is for reconsideration, which was mentioned before by Mrs. Bell. That reconsideration is simply to send the case back to Blue Cross for reconsideration. Blue Cross—or any intermediary; it could be any insurance company—they send it on to another insurance company—usually, in the case of Blue Cross, to another Blue Cross program, in our instance, in the same State, who then reviews the case and usually gives you a form letter back that they agree with the first intermediary.

So there is very little progress there. The next step, the provider cannot take——

Chairman HEINZ. Bob, I am going to have to interrupt you for this reason. There is a vote on, and I have less than 7½ minutes to get to the floor. So I am going to have to just temporarily recess the hearing for approximately 8 to 10 minutes.

So I will interrupt you there, and the hearing is recessed for 10 minutes.

[Short recess.]

Chairman HEINZ. The committee will come to order.

Bob Stutz was in the midst of making an explanation, if I recollect, of nonappeal or appeal of the decision of the fiscal intermediary.

Bob, if you would just wrap that up.

Mr. STUTZ. Very quickly, again, the provider only has the right of appeal through that reconsideration process, which is essentially done in-house of whoever the fiscal intermediary is. It is done by just a different fiscal intermediary, so it is a very small right of appeal.

The next step essentially has to be taken by the beneficiary, and that would be a law judge appeal. And again, to do that on your own usually necessitates some legal fees and so forth, that many people do not have, and I think a lot of frail elderly certainly would not appeal it that far. Then it goes up some other steps, eventually to court. But it is a long process.

The few cases that have gone through, that someone has taken through, unfortunately, once they do get to the court level, at the district court level, there is an opinion rendered, unfortunately it does not do anything except for that one case. It does not then reflect back on other decisions that HCFA makes or the intermediaries make.

Chairman HEINZ. Just to clarify it for me in one other respect, Mrs. Marie Bell described how she was getting bills, and she did not know whether she was going to have to pay the $2,000 per month bills or not. Is that a function of this limbo that first the provider and then the beneficiary get into?

Mr. STUTZ. Yes. Essentially, they do not know for many months. I assume her husband was taken into the nursing home; the nursing home probably said to her at that time—and it is a long-term care facility as opposed to the kind of facility we are—"We will apply for Medicare for you; we will not guarantee that it will be approved. If it is not approved, then we will bill you." And, I think, that is probably what happened to her. He went in; they applied, and then it came back denied, and she was billed.

Chairman HEINZ. Yes.

Mr. STUTZ. In our type of facility, we do not even have that situation. It is all Medicare. There is no other level of care to move to in that facility. So once, many months later, the care is denied by the intermediary, at that point we have no recourse, and we would not want to, go back and bill the beneficiary. Many who are in Mrs. Bell's situation certainly cannot afford the bills.

Chairman HEINZ. Thank you very much, Bob.

Our next witness on the panel is Ms. Bernice Hartzell. Ms. Hartzell, you have come from Twist, WA, where you are a home health nurse. I suspect you hold the record here today for the longest distance traversed in coming to testify.

We welcome you, and I know that both Senator Gorton and Senator Evans, were they members of this committee, would want to welcome you themselves.

Thank you for coming and please proceed.

STATEMENT OF BERNICE HARTZELL, R.N., TWIST, WA, HOME HEALTH NURSE

Ms. **Hartzell**. Thank you, Mr. Chairman.

I would add, we also hold the record probably for geographical area served. Our agency covers almost one-fourth of the State of Washington.

This testimony represents the views of a free standing, private, nonprofit home health agency in rural Washington. This agency serves five counties with a total population of 40,000. Within this geographical area are five rural hospitals which constitute the major referral base for the home health agency.

Three of these hospitals administer nursing homes. The other two hospitals have access to nursing homes within the same city. Only one of these nursing homes is certified to accept Medicare patients.

During the past year this one nursing home lost its certification twice and therefore has been prohibited from accepting new patients for periods in excess of one month each time.

The following effects have been experienced by our agency in reference to quality of care. First, patients have been discharged without adequate discharge planning, seemingly in an effort to avoid added costs to hospitals.

Two, the home health agency has had to bear the brunt of managing very difficult medical problems.

Three, the focus for the hospitals has changed from considerations of quality of patient care to issues of financial survival, and consequently, home health agencies have come to be viewed as competitors for the medical care dollar.

Four, the types of patients being discharged require 24-hour availability of nurses. This has resulted in staff burnout problems.

Five, recently, discharge planning has been stated to be a low priority for area hospitals. This has resulted in fewer referrals and a consequent recent reduction in caseload for our agency. Undoubtedly, some needy patients have been missed.

Six, costs have significantly increased while volume of service has remained essentially the same during the past 3 years.

And seven, hospital swing beds have curtailed any growth in our services.

I would also add an effect that is not related necessarily to quality of care, but is a very real effect in terms of the strain on our agency, and that is the delay in payment due to the audit processes which mean sending bills and documentation back and forth over a period of months to settle claims.

The following two case histories are examples of what is happening to some patients.

Case Study No. 1. This patient was referred to our agency by a hospital located 100 miles from our office. As a consequence of internal radiation burns and treatment for cancer, her small intestine had perforated. Management of I.V. therapy, plus care of five abdominal orifices, were the major reasons for the referral.

The success of our work with this patient was largely based on the excellent consultation we were able to obtain from the firm which supplied the I.V. equipment and supplies needed.

We experienced these unique problems in caring for the patient. To begin with, the patient was not medically stabilized. As many as four home visits were made in one day to draw blood, to make additions of electrolites to the I.V. fluids after consulting with the physician, to supervise the I.V. administration, and to troubleshoot problems.

Second, the patient's relatives who were to be available during night-time I.V. administration could not cope and were therefore not available to summon.

Third, the amount of nursing time required severely overloaded the agency's available nursing staff.

And fourth, the medical care was managed exclusively by a physician 100 miles away, by phone.

Case Study No. 2. This patient was admitted to a local hospital with a mild stroke. While hospitalized, he suffered a second, massive stroke. He was transferred 4 days later to a rehabilitation center, again 100 miles away, even though he was still unable to talk, unable to respond to questions, unable to move voluntarily, and incontinent. After 8 days in the rehabilitation center, he was discharged home to the care of his wife, in the same condition. Two days later, this man expired.

It is our strong feeling that this man was transferred to the rehabilitation center not because of potential for rehabilitation, but in order to move him out of the local hospital and thereby control financial losses.

In summary, it is our view that PPS has resulted in a focus on economics instead of patient care. Application of DRG's does not take into account the individual needs of individual patients. Hospitals have focused their efforts on utilization review directed toward controlling losses instead of discharge planning. Consequently, both quality of care and continuity of care suffer.

We consider this situation to represent a mandate to the Senate Committee on Aging to investigate further whether the objectives of quality of care and cost containment may both have been lost in the prospective payment system method of reimbursement.

While we recognize that inadequate regulations during past years have resulted in exorbitant escalating medical costs and overutilization of health care services, we believe existing regulations must be examined carefully to avoid chaos in the health care field and destruction of human lives and values.

Meeting the needs of our aging population in a quality, economically feasible way is a goal that I believe we all share.

Chairman Heinz. Ms. Hartzell, thank you very much for some excellent examples and some very eloquent testimony; indeed, I think your summary hits the nail on the head.

What we have really heard from all of you is a pattern of how Medicare beneficiaries are really having problems gaining access to post-acute care, how the decisions of the fiscal intermediaries compound this problem of reimbursement and create either financial hardships or grave uncertainty for the patient; how decisions on transfers from one level of care to another, as just described by Ms. Hartzell, are to my mind absolutely unjustifiable.

On behalf of the committee, I want to thank each of you for having come quite a long distance, to share with us your excellent testimony.

Chairman HEINZ. Our last panel includes Mr. William Dombi, the Reverend Roland Hornbostel, and Ms. Hollis Turnham.

We welcome all of you. We are fortunate, I really believe, to have in this panel with each of you today, experts on how the quality assurance program is, so to speak, working or not working, more appropriately.

I appreciate the willingness of each of you—each of you are Medicare patient advocates—to invest the time from what clearly must be an absolutely overwhelming job for each of you in light of the statistics that have been presented to the committee, with no help to you from the administration, I might add.

Let me ask Mr. Dombi, who is an attorney from Legal Assistance to Medicare Patients, LAMP, in Connecticut, who is here to describe his experience in filing literally hundreds of Medicare appeals for Medicare patients who were denied Medicare home health and nursing home benefits, to be our first witness.

Mr. Dombi?

STATEMENT OF WILLIAM A. DOMBI, ESQ., CODIRECTOR, LEGAL ASSISTANCE TO MEDICARE PATIENTS, WILLIMANTIC, CT

Mr. DOMBI. Thank you, Senator Heinz.

My name is William Dombi, and I am the codirector of a program known as Legal Assistance to Medicare Patients. To many of the residents of Connecticut, we are known as LAMP.

We have been in existence since 1977 with one function, and that is to represent individuals who have experienced problems with the Medicare Program. It appears today the only way that an individual cannot experience a problem with the Medicare Program is to stay young and healthy.

Each year we represent well over 1,000 residents of the State of Connecticut, in beneficiary appeals for skilled nursing facility, home health, hospital, and all the other assorted Medicare coverage areas that exist.

Senator Pressler asked earlier whether the staff could undertake an investigation to determine whether the problem is the law, or is the problem the administration. I can tell you, after 8 years of doing exclusively Medicare advocacy, the law is pretty good; the administration is very bad.

Through the years, the Health Care Financing Administration has circumvented the law and subverted the intent of Congress. They have done this through oral and written policy directives, all designed to curtail coverage.

There are two Medicare programs, the one that is on the books under 42 U.S.C. 1395, and then there is the policy manual, and the Health Insurance Manual, and the oral and written directives of the Health Care Financing Administration—two separate programs, which leave people like Mrs. Bell and providers of services throughout the country at a loss to understand why something is not covered.

Two major growing problems are occurring as a result of the prospective payment system, and that is the ripple effect on the home health care benefit and the skilled nursing facility benefit.

The Health Care Financing Administration has, in my mind, undertaken an attack on the home care benefit. They do not like what is being covered; it appears it is too much for their purposes. And so they are designing policies which go to the heart of the coverage interpretation.

For example, the Medicare law provides that part-time or intermittent home health services would be covered. For years, that posed no problem for providers of services, nor did it pose problems then for beneficiaries. Suddenly, the administration chose to redefine the concept of intermittent care. They started to distinguish between daily services and intermittent care for the first time in 15 years. But they did not stop there, because they defined "daily" as including 4, 5, and 6 times a week care. The result was that thousands of people across this country lost full Medicare coverage, and many of those individuals later deprived themselves of services.

Beyond that, HCFA has put pressures on the providers of services to be extremely restrictive in their coverage interpretations. Specifically, the compliance audit reviews undertaken nationwide were performed with the vigor of storm troopers in Europe. Providers of services felt extremely threatened and as a result, decided not to submit claims for future patients. The cost limits which have been proposed through the Health Care Financing Administration would have the direct impact of reducing the frequency and duration of home health aide services provided to individuals. The norms of care which are at issue in the DRG's are equally at issue, then, through the cost limits in the home care benefit. If a provider of services stands to lose money as a result of caring for a patient with a 4-hour visit, they will not service that patient.

And finally, a pressure on the provider of services is the waiver of liability, which waives liability more for the Medicare Program than it does for the providers of services or the beneficiaiy. It is the most sophisticated brainwashing and threatening system known in the insurance industry.

The skilled nursing facility benefit as well has been dismantled, only it has been dismantled since 1970. However, it is taking on new and increasing importance today as a result of the earlier discharges from the hospitals. Such unwritten rules as the 2-week physical therapy rule have led to lost rehabilitation for individuals who have transferred from hospitals to nursing homes.

As Mrs. Bell experienced, they expect ill and elderly individuals, double amputees, to be dancing at a disco on a Saturday night, or they have no rehabilitation potential at all. An individual who is then discharged from a hospital prematurely and is subjected to this 2-week rule has not progressed to the level even of a walker or the capacity to navigate stairs, and finds himself eventually imprisoned in a nursing home. They are incapable of returning to the community.

In conclusion, I would like to offer a few recommendations for this committee to consider.

The first is that any further consideration of the use of the prospective payment system and the DRG's should coordinate its impact on the home health and skilled nursing facility benefit. At this point in time, those two stopgap measures have been ignored.

Formal coverage regulations should be imposed, rather than the use of this secret law. At present, there are no formal regulations defining the home care benefit, which leaves it to the whim of HCFA to continually redefine the program.

Some sort of preadmission or pretermination protection should be imposed for the skilled nursing facility and home care benefits, because we have some across countless cases where individuals, when faced with the loss of Medicare coverage, make the difficult choice of depriving themselves of services.

And finally, Mrs. Bell's problem highlighted this extremely well. There is no requirement for providers of services to submit claims which would lead to a formal determination of noncoverage. At present, I have offered my services through the ombudsman to help Mrs. Bell out through that maze, and it is just a maze. There is something known as the no payment billing which, according to the intermediaries, lead to a full and fair review of the claim determination. I question whether a claim that came before me which had the black-letter type on the top of the paper, "No payment billing", would lead to anything other than a no-payment.

I would offer the services of Legal Assistance to Medicare patients——

Chairman HEINZ. How about something that says, "This is a no-payment billing. You must remit before September 4."

Mr. DOMBI. "You must remit before September 4." Well, providers of services do need their money, and beneficiaries do need their coverage. Unfortunately, both in skilled nursing facilities and home care, that is not happening either quickly, or is it happening competently.

Mrs. Bell is in for a long fight. Our typical client right now is waiting for a reconsideration determination in excess of 100 days, and waiting for a fair administrative law judge determination approximately 175 days. And then if you win, you have got a 2- to 3-month wait thereafter to get your money back.

Chairman HEINZ. Mr. Dombi, do you have any other good news for us?

Mr. DOMBI. I am a Medicare cynic. My dinner-table discussion too often concerns Medicare, my wife's disagreements with that aside.

The only good news I have to offer is that we are trying to duplicate our program's existence in other parts of the country. We have found a way of doing that cost free to the States, and it is kind of an amusing way of doing it. The Medicaid programs are paying for the services we are providing to Medicare beneficiaries, because one of the victims of the cost shift is not only the patient but the Medicaid programs nationwide. And we have proven ourselves extremely cost effective for the Medicaid program to employ our services in order to avoid pauperization of the elderly and then avoid Medicaid eligibility.

That is the only good news I have.

Chairman HEINZ. Well, at least there is a little bit of good news. Thank you very much for your excellent testimony.

Mr. DOMBI. Thank you, Senator.

[The prepared statement of Mr. Dombi follows:]

PREPARED STATEMENT OF WILLIAM A. DOMBI

I. INTRODUCTION

Legal Assistance to Medicare Patients [LAMP], is a project of Connecticut Legal Services, providing legal representation to Medicare beneficiaries throughout the State of Connecticut. LAMP began its operation in 1977 and has since represented thousands of Connecticut residents in appeals of Medicare coverage denials. LAMP has provided direct individual representation at administrative appeals, engaged in class action litigation, provided extensive community education, and has assisted Congress and its committees in deliberations regarding Medicare Amendments and problems. LAMP has also worked with various individuals and organizations across the country in hopes of extending Medicare advocacy.

LAMP has provided legal services to individuals who experience problems with any area of the Medicare program. However, the LAMP program has focused primarily on skilled nursing facility and home health care services which, based on our experience, represent the areas of Medicare coverage most often subject to erroneous coverage denials with an opportunity for successful appeal. In addition, we have assisted numerous patients who have been denied coverage in the hospital setting or who have experienced problems with the administration of the Medicare Part B program, primarily coverage of physician services.

The purpose of LAMP's testimony is to explain to this committee that the prospective payment/DRG hospital payment system not only has an adverse impact on patient care in the hospital setting, but also leads the patient into a system of alternative care for which the Medicare program is unwilling to provide adequate coverage.

Through the use of oral and written policy directives, the Health Care Financing Administration has subverted the intent of Congress as embodied in the law. These policy directives have led to an extremely reduced or restricted home health and skilled nursing facility benefit. HCFA has not only tightened program coverage guidelines, it has imposed pressures upon providers of services and fiscal intermediaries to often force an unwilling ally to deny Medicare coverage. Caught in the middle is the patient, who when faced with a Medicare denial, will often deny themselves care.

II. MEDICARE HOSPITAL BENEFIT: THE DRG INITIATED DISCHARGE

The focus of the Senate Special Committee on Aging's investigation is to develop a better understanding of the quality of care problems which result from Medicare's new prospective payment system whereby hospital facilities are paid on the basis of the patient's diagnosis [DRG]. Currently, the protective measure contained within the Medicare program designed to "assure" quality of care is the Peer Review Organization [PRO].

It is apparent from recent statistics that the DRG/PRO system has certainly succeeded in achieving some level of cost containment of the Medicare hospital benefit. With an overall reduction in access of one day of hospital stay for the average patient, costs are being controlled to some degree. The question remains as to how this system has affected the quality of care.

While LAMP has neither the resources nor the expertise to examine the important issues surrounding premature discharges from hospitals, we have had the opportunity to view individual cases that one might consider as premature discharges. Our conclusion is that the current system of notice to patients and PRO review does not provide an adequate protection. The following case example may highlight this.

On November 15, 1984, a Connecticut resident in his seventys entered a community hospital following a cerebrovascular accident, a stroke. After a period of rehabilitative services, this individual was discharged home on December 20, 1984. He was brought to his home by an ambulance crew where his wife was awaiting his arrival.

When the ambulance crew transported this individual into his home, his wife inquired as to the nature of the smell about her husband. The crew indicated that the smell was there when they had picked the patient up and they had no idea as to the cause. After a brief examination, the wife determined that the nature of the smell was a four inch wide decubitus ulcer above the coccyx. The ulcer was draining serous fluid and from a layman's perspective, it appeared infected.

Since this was holiday time, the wife could not make contact with the attending physician to discuss the matter. After several days of trying, she finally reached a physician who immediately had the patient readmitted to the hospital where he remained for the next month and a half.

There was no PRO review of this patient's continued stay at the hospital. Based on LAMP's review of the facts, it appears that the discharge from the hospital was initiated through the hospital administration. Clearly, there are questions of quality of care which involve the attending physician, the hospital nurses, and the hospital administration. Nevertheless, the designed protection, the PRO, was absent from this process. In excluding the PRO, the hospital did no wrong under current regulations and guidelines.

A PRO becomes involved in a continued stay determination at a hospital only if the patient remains as an inpatient after the hospital determines that further care would not be covered under Medicare. In fact, it is HCFA's position that the hospital need not provide a written denial notice to the patient if that patient leaves the facility on or before the date when the hospital feels the care should not be covered by Medicare. Under federal law, 42 C.F.R. § 412.42, the hospital cannot charge the patient for care until the third day after the date of written notice. Patients who have been told to leave the hospital as a result of a Medicare denial determination by the hospital, therefore have a right to continued stay for discharge planning purposes and thereafter a right to a written notice regarding the PRO process and appeal. However, it is only the patient who stays in the facility after the hospital decision, who gets any such written notice of opportunities to turn to the PRO for resolution of a complaint. LAMP would encourage this committee to advise HCFA that the process must provide full written notice by the hospital at any time when the hospital concludes that a patient is no longer receiving a Medicare covered level of care.

Nevertheless, the simple truth of the matter is that when patients receive an adverse decision, written or unwritten, regarding continued Medicare coverage in a hospital, they leave the facility. Even with the expedited review available to patients in the PRO process, patients would have to assume a substantial financial risk with a continued stay. When the average cost of a days stay in a hospital is approaching $500, a three day stay for an expedited reconsideration by the PRO can leave the patient with a $1,500 bill. Therefore, instead of waiting and challenging the hospital determination, patients find themselves discharged to alternative levels of care where Medicare coverage is also absent.

III. HOME HEALTH CARE

The individual discussed above was not only subject to a premature discharge under the prospective payment system, but also later found himself in the midst of a Medicare denial of home health services. That denial took over five months to favorably resolve through the administrative appeals process and even now the procedures at work in the system have not led to a reinstatement of Medicare coverage for his home health services currently received.

The brunt of the impact of DRG related Medicare denials appears to have hit the home health benefit. Since 1981, the home health benefit has been systematically attacked by the Health Care Financing Administration. That attack has been stepped up since the initiation of the prospective payment system in hospitals. The approach taken by HCFA can be divided into two spheres: first, direct policy changes on Medicare home health coverage interpretations; and second, policy changes designed to increase the pressures on providers of services to discourage Medicare claim submissions.

A. Coverage policy interpretations.—On July 1, 1981, Amendments to the Medicare program took effect whereby the home health benefit was greatly improved. These Amendments eliminated the 100 visit restriction under Medicare Part A and Part B and also eliminated the prior hospitalization requirement. Under current law, a Medicare beneficiary can qualify for an unlimited number of home health visits provided that beneficiary demonstrate a need for intermittent skilled nursing care or physical or speech therapy while being confined to the home. In addition to nursing and therapy services, the home health benefit would then provide coverage for part-time or intermittent home health aide services and the services of medical social workers.

On the same day the new law took effect, HCFA implemented new policy regarding the definition of "part-time or intermittent" care. Ostensibly, the new policy merely established a new norm of care. However, it had been HCFA's recognized experience that norms of care lead to limits on coverage rather than the establishment of helpful guidelines. The norm of care had been changed from 20 hours of aide services per week to approximately 6 hours of aide services a week. Immediately, fiscal intermediaries were imposing strict limits on Medicare coverage for aide services. At the same time, home health agencies began restricting claims for Medicare coverage of home health aide services.

Caught in the middle of all this was the Medicare beneficiary. A LAMP client, Anna Mazzola, filed suit through her conservator, Gloria Morris, since she had suffered a dramatic reduction in her Medicare coverage. After years of litigation, the policy was amended by HCFA following the trial. While the policy has been improved, Anna Mazzola, now deceased, suffered through three Medicare coverage denials, with two successful administrative law judge's appeals and a third in progress. She also suffered through reduced services and increased pressures on her primary care giver, her daughter. These pressures continue today on patients throughout the country and upon providers of services who have the difficult task of meeting the confusing demands of Medicare coverage guidelines.

HCFA, dissatisfied with its limited success in achieving control of the home health benefit through the "part-time or intermittent" definition, then attempted to redefine the homebound requirement of Medicare law. At the time, the homebound policy allowed for flexibility and practical application. HCFA's drafted amendment would have imposed extremely restrictive requirements, nearly approximating a bedbound, rather than homebound standard. Through the efforts of Medicare advocates, the home health agency industry, and members of the Senate and House Committees on Aging, the policy has been shelved, at least for the moment.

In what appears to be a direct response to the increased severity of medical condition of patients discharged from the hospital, HCFA, through its intermediaries, began a new approach in 1983 to the intermittent care rule. For the first time since the inception of the Medicare program, HCFA determined that intermittent care did not include daily services. Intermediaries across the country set fixed limits on daily services ranging from 2 to 6 weeks. In combination with the fixed limits, the intermediaries chose to define "daily" as including 4, 5, and 6 times a week services to patients. With the increased need for care resulting from a DRG related discharge from the hospital, patients were finding themselves at home and without Medicare coverage.

An example of a typical patient was Kenneth Miller a resident of South Windsor, Connecticut. Mr. Miller was terminally ill and wanted to die at home. However, his 6 weeks of daily services were coming to an end. For Mr. Miller daily meant 5 and 6 times a week care that supplemented the services provided by his daughter. When the home health agency contacted the fiscal intermediary to ask for an extension, the response was that they were not concerned whether Mr. Miller was going to die tomorrow or in several weeks, his 6 week period of daily services was up.

Fortunately, the home health agency providing Mr. Miller care was concerned and contacted the LAMP program. As a result of litigation, Mr. Miller was reinstated to Medicare coverage and the Medicare policy has been changed nationwide. However, prior to that lawsuit, thousands of elderly, infirm individuals across the country were denied Medicare coverage and lost necessary health services.

Recently, the fiscal intermediary in Connecticut implemented a new coverage policy again dealing with the "part-time or intermittent" requirement. This new policy had the intermediary reviewing not only care provided by the home health agency, but the personal care services provided by family members to an infirm patient in the home. It became the position of the intermediary that when family care combined with home health agency provided care exceeded the intermittent care rule, then no Medicare coverage would be granted. For example, if a patient were receiving home health aide services 5 times a week from an agency for 2 hours a visit, and that patient's care was supplemented by regular, daily services from family members, that patient would be entitled to no Medicare coverage if the level of need was expected indefinitely. Therefore, 10 hours a week of aide services was determined to be more than part-time or intermittent care. This policy is directly contrary to the philosophy of home health care which is intended to involve family members as an economical means of providing health care at home. It is and was both morally and legally indefensible as HCFA has agreed to settle the lawsuit brought on behalf of a class of recipients affected.

For at least one individual in Connecticut, the lawsuit did not help. The individual involved was a victim of Lou Gehrig's disease, A.L.S., who was cared for primarily by his wife. When subjected to a Medicare coverage denial for the 7 to 10 hours of aide services received each week, the patient's spouse was unwilling to challenge the determination. She stated instead that the pressures of caring for her husband were already great and she did not need and could not handle the additional pressure of a challenge to a Medicare decision. She choose to forego necessary health care and try and make it on her own. In such circumstances, two victims of A.L.S.

usually develop: the patient and the care giving spouse who cannot physically or mentally provide 24 hour care on her own.

Of recent origin is the oral instruction from the Central Officer of the Health Care Financing Administration to intermediaries regarding the payment for home health aide services provided after the final skilled home visit by nurses or therapists. This instruction was conveyed at a recent meeting of intermediary officials at HCFA in Baltimore. Essentially, that instruction limited payment of home health aide services to care provided before the final skilled visit. With the instruction, no distinction was made between varying circumstances of patients.

With the lack of distinction between patients' circumstances, patients who have a scheduled monthly nursing visit for a catheter change and who die shortly before the next planned visit, would find themselves outside of Medicare coverage for up to four weeks of aide services. Of a similar circumstances is the patient who has an acute episode of illness which requires hospitalization prior to the scheduled skilled visit. The ultimate result could be as much as several hundreds of dollars of debt left as a legacy or unexpected liability for the hospital patient. Since the instructions were that such a denial of coverage would be a technical denial, the waiver of liability would not have applicability to protect the patient from a retroactive coverage determination.

It is LAMP's current information that HCFA has had second thoughts about issuing the policy change in writing. This change of heart appears to have developed after LAMP wrote to the Regional Counsel for HCFA explaining the legal consequences of such action.

Assorted other issues regarding policy coverage determinations have developed over the past year. Included within these is an apparent interpretation of Medicare coverage policy which excludes home care services to most patients on renal dialysis. It has become the position of the Connecticut fiscal intermediary that renal dialysis patients can receive any and all skilled nursing services required at the dialysis clinic, and therefore do not meet Medicare conditions of coverage. This would include individuals who have infected open wounds requiring changes of dressings. To perform such a task in the setting of a renal dialysis clinic would put all patients at risk. Furthermore, dialysis clinics are equipped with specialists in dialysis whose intended function is limited to the renal care of patients. The dialysis clinics have indicated that they have no desire nor competency to provide care to patients beyond renal dialysis.

Similarly, it is the position taken by the Connecticut intermediary on physical therapy to home care patients that unless a patient had a "PT related diagnosis" that the patient could not require skilled physical therapy. A PT related diagnosis was limited to neurological and neuromuscular disorders to the exclusion of such debilitating illness as congestive heart failure. When confronted with this issue, the regional office of HCFA denied its existence whereupon written confirmation of such decisions was provided. Thereafter, HCFA informed the intermediary not to use such language in its denial process. The clear implication is that HCFA approved of the actual denials, but did not approve of the language used to effectuate the same.

Finally, the intermediaries have become increasingly restrictive in their determination as to the medical necessity of care provided. A typical example is a retrospective review by the intermediary whereupon the conclusion was reached that the frequency of skilled services needed was not as great as the frequency rendered. However, when determining that five out of ten nursing visits were not medically necessary, the intermediary has been unable to explain which five were necessary and which five were not.

B. Pressures on providers to deny coverage.—Since the inception of the prospective payment system in hospital care, there have been new, stepped-up pressures on providers of services to limit claims submission to the Medicare program. It is the provider of services who has the real option in determining whether a claim is to be submitted to Medicare. In the absence of a claim, there is no coverage determination issued by the intermediary which is subject to appeal. By allowing the providers to screen cases out at the claims submission level, the intermediary has insulted itself from most decision-making which could demonstrate the true nature of the current home health benefit.

While LAMP does not represent providers of services, it is in a position to analyze and review policy changes which are provider directed and have a beneficiary impact. LAMP has worked hard to develop good relations with the provider industry and has reached the point where providers often seek beneficiary-oriented advice and counsel from LAMP staff members.

The most direct and obvious provider-oriented policy change which has had impact on beneficiaries is the prohibition by HCFA of provider representation of patients. This recent change has set up an across-the-board prohibition of provider representation in the Medicare appeals process. While the policy was directed to all providers, hospitals, skilled nursing facilities, and home health agencies, its greatest impact occurred at the home health agency level. The home health agency providers across the country had undertaken a campaign to challenge Medicare coverage determinations which came about as a result of restrictive policy interpretations and amendments. With the absence of advocates in all jurisdictions who could represent aggrieved Medicare patients, the providers had taken on the challenge and pursued Medicare appeals.

The recently published cost limits for home health services act to discourage provision of proper levels of care to patients. With the cost limits developed through a non-aggregation of discipline costs, the payment rate for home health aide visits is likely to lead to decreased access to high intensity care patients and also to limit services delivered to patients who need aide visits in excess of three hours.

The average cost per hour of aide services to a home health patient exceeds ten dollars in most areas of the country. In fact, it may rise as high as fifteen dollars an hour, depending upon location. When the rate of payment is limited to just over thirty dollars, the natural impact is to discourage home health agencies from providing care beyond a profitable or break-even level. It is recognized that the cost limit is to be applied in such a way as to include patients with short duration services as well as long duration services. However, the limit on payment discourages the delivery of extended services. The "norm of care" structure with DRgs has had a similar effect. The impact can be expected in terms of increased hospital admissions resulting from inadequate home care, increased institutionalizations resulting from limited access to care, and possible death of patients.

Two final policy actions by HCFA are also worthy of note. First, recent compliance audit reviews by fiscal intermediary staff have created an atmosphere of apprehension among the provider industry. Not only must such review functions of the intermediary meet set cost effective standards ($5.00 to $1.00), the primary qualification for intermediary reviewers is that they have the authority to deny coverage. With all due respect to HCFA and its intermediaries, it is LAMP's opinion that the intermediary reviewers approached their responsibility for compliance audit review with all the vigor of a storm trooper, overzealously responding to the desire to deny coverage.

Second, the proposed overhaul of the waiver of liability system both through the sampling methodology employed and the sampling methodology currently employed and the proposal to eliminate the favorable presumptive status, worsens a bad system. Providers ran scared from the pressures of shifted liability that would result from a loss of their waiver status, with that gone, the incidence of claim submission for covered care will be reduced further.

IV. UNJUST DENIAL OF MEDICARE SKILLED NURSING FACILITY BENEFITS

Each month thousands of aged and disabled citizens leave the hospital and enter skilled nursing facilities. Suffering the effects of severe and disabling ailments, many of these patients need daily skilled nursing or rehabilitation services. Although their need for daily skilled services should trigger these patients' rights to Medicare SNF coverage, the Health Care Financing Administration has adopted a practice of wholesale and arbitrary denial of meritorious claims; despite the attending physician's certification that skilled nursing facility care is needed, and the physician's explicit order that such care be rendered, nearly all of these patients will be denied without a single day of Medicare coverage.

Since 1977 Legal Assistance to Medicare Patients has advocated on behalf of Medicare beneficiaries struggling to obtain a fair determination of their entitlement to Medicare SNF coverage. Over the years we have represented SNF patients at more than 600 administrative hearings, winning additional benefits in more than 75% of all decisions rendered. Despite our efforts, however, HCFA continues to deny skilled nursing facility coverage on a wholesale basis. Available data documents HCFA's remarkable success in suppressing the SNF benefit. For example, the total number of Medicare-paid SNF days in Connecticut in fiscal year 1975 was 217,812; in fiscal year 1982, the number of Medicare-paid days had fallen to 90,443—a reduction of 58 percent. Between fiscal year 1978 and 1979, the number of Medicare-paid days fell from 146,637 to 75,086—a reduction of 49 percent in one year. Since the total number of SNF days, regardless of payor, rose 21 percent during the seven year period, the percentage of Medicare-paid days in relation to the total fell even faster—a reduction of 65 percent over seven years.

The human import of Medicare's denial of SNF coverage is constantly apparent to Legal Services advocates working in the Medicare area. After a brief hospital stay, an elderly patient will be informed that Medicare coverage has been terminated, and that the cost of additional hospital care, often as much as $500 per day, must be borne by the patient alone. In order to avoid these charges, many patients, too sick to return home, are forced to search hurriedly for nursing home placement. Upon admission to the nursing home, a patient will almost certainly be denied all Medicare SNF coverage. In our experience, the elderly rely very heavily on the expectation of significant Medicare coverage. They reassure themselves that "at least Medicare will pay for 100 days of nursing home care." They are bewildered and hurt to find that Medicare help in the nursing home is virtually nonexistent. Without Medicare assistance, the nursing home resident is forced to pay the bill. Lifesavings, and the psychological security they represent, are destroyed. Patients become indigent, and they must seek Medicaid medical assistance; they are "forced onto welfare." There self-respect plummets as they realize they are a burden to their families, and to the State.

Even more serious is the tendency of patients to deny themselves essential health care services once Medicare SNF coverage has been unfairly denied. Medicare patients needing daily physical therapy services after strokes or broken hips provide a particularly poignant example of this tragic situation. When Medicare denies coverage, many patients decide to forego medically necessary physical therapy which has been ordered by their physicians. Since nursing homes often make an additional charge for physical therapy services after the Medicare denial, patients can economize by declining to purchase physical therapy. During testimony at trial before the United States District Court for the District of Connecticut in 1984, Mrs. Blanche Fox, widow of Medicare beneficiary Walter Fox, testified that the denial of Medicare benefits forced her to discontinue her husband's therapy:

Question. What did you decide to do about that extra cost:

Answer. Well, I had to drop it because I couldn't afford to carry it. I couldn't afford it.

Question. Did your husband receive physical therapy after that?

Answer. No.

Question. What happened to his condition?

Answer. He would get so he couldn't hardly move at all. In fact, he got so he couldn't move on his own. He couldn't stand.

Question. Did he need hospital care after that?

Answer. Yes; he got pneumonia because he couldn't move, he also got ulcers, bedsores, because he wasn't moving or anything.

Premature and inappropriate denial of Medicare SNF coverage not only leads to medical harm to the beneficiary involved, but it is also profoundly uneconomical. When proper medical care is not delivered, patients are unable to regain their ability to live independently. They remain in the institution until their private finances are exhausted and they are forced to turn to Medicaid assistance. Ironically, if fair Medicare coverage was available, many more patients would attain full restoration and return home, saving themselves and the Government untold millions of dollars. Tragically, HCFA has chosen to employ the practice of arbitrary denial, thereby damaging both the plaintiffs and the public fisc.

After years of study we at LAMP have identified three fundamental causes of the unjust and damaging suppression of the Medicare SNF benefit: (1) the coverage determination process is fundamentally biased against the granting of benefits; (2) intermediaries tend to arbitrarily deny meritorious claims; and (3) intra-system corrections are completely inadequate. *1. The bias against the granting of benefits.*—

When the patient enters the skilled nursing facility, the provider has the duty to decide whether Medicare coverage should be granted. HIM-13, § 3439.1. This requirement derives from 42 U.S.C. § 1395pp, entitled "Limitations On Liability Where Claims Are Disallowed." This statute was passed to protect against teh abuse of retroactive denials by excusing the beneficiary from liability for the cost of care received until the beneficiary is informed in writing that Medicare coverage will be denied. Sen. Rep. No. 92-1230, p. 294; 42 U.S.C. § 1395pp(a); 42 C.F.R. §405.332. The statute also provides, however, that the provider will be held liable for the cost of services if the provider should have known that the care was excluded from coverage. 42 U.S.C. §1395pp(b).

Of fundamental significance here is the fact that only a grant of coverage subjects the provider to a risk of financial penalty. When the provider determines that the care is covered, no denial is given to the beneficiary and the provider files a claim for payment using the billing portion of HCFA Form 1453. If the claim for payment is rejected by the intermediary, the provider would ordinarily be required to absorb the cost of the care given the patient between the date of admission and the date on which the written notice of noncoverage is finally delivered to the beneficiary. 42 U.S.C. § 1395pp(b).

In some circumstances, however, the provider will be presumed to be without fault in failing to deny the claim initially, despite the fact that the intermediary has reversed the provider's grant of coverage. 42 C.F.R. § 405.332. The provider will earn this favorable presumptive status by meeting a "denial rate criterion" established by the Secretary. HIM-13, § 3433. If the number of days of care determined by the provider to be covered and billed to the intermediary, but then denied by the intermediary as noncovered, amount to fewer than five percent of the total of all days of care determined by the provider to be covered and billed to the intermediary, then the provider has satisfied the denial rate criterion and is entitled to the favorable presumption. HIM-13, §§ 3433, 3434. When a provider entitled to the waiver presumption submits a grant of coverage to the intermediary, it risks being reversed by the intermediary, which will adversely affect the provider's denial rate, possibly forcing the denial rate over the five percent limitation and subjecting the provider to liability for the cost of the days of care at issue. 42 C.F.R. § 405.195; HIM-13 § 3433.

In contrast, the provider incurs no risk what ever if it merely denies the claim. In such a situation, the provider advises the beneficiary of the denial in writing. No claim for payment is submitted unless the beneficiary affirmatively insists. HIM-13, § 3439.1. Only the "admission" portion of HCFA Form 1453, Inpatient Hospital And Skilled Nursing Facility Admission And Billing, is sent to the intermediary. Based on the admission notice alone, the intermediary will issue the beneficiary an initial determination denying coverage.

If a provider denies coverage and so notifies the beneficiary, all risk of fiscal penalty is avoided. Because no days of care elapse between the start of care and the delivery of the notice of non-coverage, the beneficiary alone is responsible for the cost of his/her care. These provider denials are never questioned or reversed by the intermediary, nor do they figure in any way in the computation of the provider's presumptive waiver status.

Providers in Connecticut have testified to the coercive "chilling effect" of this coverage determination process. Rather than run the risk of incurring a financial penalty, providers will simply deny all but the most obviously covered cases.

2. Arbitrary denials by intermediaries.—Providers would not deny coverage to meritorious cases unless they feared that the intermediary would deny those same cases if the provider was to submit them as covered. In fact, it is all too clear that intermediaries routinely deny coverage to cases of overwhelming strength. Our client Grace Goodrich, for example, entered the SNF from the hospital after an amputation of her left leg below the knee. Mrs. Goodrich received intensive skilled services as the SNF staff tried to save her gangrenous *right* foot. They were unsuccessful, and after 61 days Mrs. Goodrich entered the hospital for a second amputation. Nevertheless, Mrs. Goodrich was denied coverage both by the provider, and by the intermediary on reconsideration.

While the *Goodrich* case is particularly outrageous, the intermediary practice of arbitrary denial of clearly coverable claims is demonstrated in hundreds of our cases.

3. Inadequacy of intrasystem correction.—We at LAMP are convinced that the present unjust SNF coverage determination process survives simply because no powerful interests oppose it. SNF patients themselves are particualrly vulnerable. Ill and elderly by definition, usually under severe financial pressure, these beneficiaries are rarely able to fight on their own for the coverage they deserve. Figures supplied to us by HCFA show that only .3 percent of all SNF denials are appealed as far as administrtive hearing. The corrective effect of such a small number of appeals is negligible.

LAMP is the only program in the nation representing substantial numbers of Medicare beneficiaries in administrative appeals. Yet even in Connecticut, we are unable to assist more than a fraction of the beneficiaries affected. Approximately 2,200 initial denials of SNF coverage are issued in Connecticut each month; LAMP is able to represent an average of only 80 of these potential claimants. Nor is federal action litigation the answer. It takes five years to get to trial in District Court in Hartford. Each case requires an enormous commitment of lawyer time and expense, and even when we win a case, government appeals can be expected to cause additional delay and expenditure of resources before our clients see any real benefit.

The usual corrective influences of administrative review and federal litigation are plainly inadequate to bring reform of the SNF coverage determination process. If the system is to be improved, Congress itself must show a new willingness to examine coverage procedures with a critical eye and make changes. The Congress must take responsibility to see that SNF claimants are treated fairly.

V. CONCLUSION AND RECOMMENDATIONS

As has been stated above, it is LAMP's position that HCFA has dismantled the skilled nursing facility benefit over years and is in the process of doing the same to the home health benefit. The successes of the skilled nursing facility benefit distruction have whetted the appetites of HCFA officials in their attack on Medicare coverage of home services.

LAMP recognizes the existence of an appeals process which is designed to provide retrocative monetary relief to patients who have suffered through an erroneous Medicare coverage denial. This is not enough. For the following reasons, LAMP recommends this Committee consider a revamping of the procedural protections available to Medicare beneficiaries to avoid erroneous terminations of Medicare coverage.

(1) The Medicare population is aged and aging every day. Those most intimately affected by a coverage determination are elderly and infirm, dependent upon their care providers in order to survive. This population is vulnerable, non-aggressive, and not self-assertive. With a massive program like Medicare, the frequency of appeals is extremely low. Simply put, sick people in hospital beds, skilled nursing facilities, and home bound do not file Medicare appeals.

(2) The claim submission process controlled by the providers of services insulates the Health Care Financing Administration and its intermediaries from the utlimate decision-making responsibility mandated by Congress. With providers of services under threatening pressure of shifted liability and confronted with confusing and ever-changing policy guidelines, claims are withheld and Medicare enrollees go without benefits and an opportunity to appeal. Statistically, the result is that HCFA can claim that they are paying for a high percentage if not all of the claims submitted. Their statistics are extremely flawed.

(3) For those few individuals who are courageous and vigorous enough to appeal, the remedy of retroactice monetary relief often comes too late. At present, it takes between 3 and 4 months for the intermediary to process a reconsideration and an additional 6 months for an administrative law judge to process a hearing. A 9 months wait for benefits led to the foreclosure of one of our client's homes. Shortly after the foreclosure, retroactive benefits were awarded. It did not prevent the loss of her home.

(4) The most harmful impact of erroneous coverage determination in hospital, skilled nursing facility, and home health care is the increasing likelihood that beneficiaries will deny themselves care. LAMP has mentioned a number of cases in this statement where beneficiaries chose to forgo necessary medical care following a Medicare coverage denial. These people, just as the individuals involved in care without a claim submission, do not appear in HCFA statistical reports. Nevertheless, it is a real and on-going problem that the Medicare program refuses to recognize. The delivery of health services is intimately tied to the availability of payment. When Medicare coverage is denied, there is not just a shift in financial responsibility to Medicaid or to private insurers. Lost care is often an additional result.

LAMP encourages this Committee to require that HCFA cease issuing benefit changes and restrictions through unpublished written and oral directives. Furthermore, LAMP recommends that HCFA be required to promulgate formal regulations through the Administrative Procedures Act process, particularly in the area of home health care where no regulations have been devised on important coverage issues. LAMP also recommends that this Committee give serious consideration to the institution of preadmission and pretermination protections for skilled nursing facility and home health care patients. Finally, LAMP strenuously recommends that this Committee undertake whatever action is necessary to require that claims be submitted for all care rendered to Medicare patients by Medicare certified providers. This is the only mechanism available to calculate the true effect of the Medicare determination process.

Chairman Heinz. Reverend Hornbostel?

STATEMENT OF REV. ROLAND HORNBOSTEL, CLEVELAND, OH, NURSING HOME OMBUDSMAN

Reverend HORNBOSTEL. Thank you. My name is Rev. Roland Hornbostel, and I am not, as noted on the agenda, a Medicare ombudsman. I do not think it would be a wise idea to identify with that program today. However, I am a nursing home ombudsman from Cleveland, OH, and I have been for 8½ years.

In addition to investigating complaints about nursing home care, our organization also provides placement assistance to families in the Cleveland area who are looking for suitable nursing homes or board and care alternatives to nursing homes.

Chairman HEINZ. Reverend Hornbostel, let me just say that I note that you will be abbreviating your statement somewhat, but I want you to know that your entire testimony will be a part of the record.

Reverend HORNBOSTEL. Thank you very much. I do appreciate that.

In the past year, we have assisted about 1,200 families in locating suitable long-term care placement. And it is this work with families in locating placement that has led to our growing concern about the effect of the prospective payment system on the lives of our elderly citizens.

The largest problem we have observed is that nursing homes and other long-term care settings are really ill equipped often to handle the needs of the people they are getting from hospitals quicker and sicker. This manifests itself in a couple of different ways. One is that in the Cleveland area, nursing homes have had to set up informal quota systems—so many tube feeders, so many patients needing hyperalimentation, so many patients needing physical therapy, and then they will not admit anymore patients needing that form of care even if we have to leave the bed open. We question whether that is cost-effective or desirable.

A variation on this problem is those nursing homes—frequently those that are most substandard—that are so desperate for patients, is they will admit anybody despite whether or not they are able to meet those patients' care needs. And that has become a very big problem.

The second type of problem involves the coverage that Medicare provides for skilled nursing facility benefits, and that has been alluded to frequently. I just want to add that there are basically two bars to a person like Mrs. Bell asserting her rights. First of all, there is the bar of being informed that you in fact have rights to appeal. Many, many elderly people do not know that they can appeal determinations under the Medicare Program.

A second bar to a person like Mrs. Bell asserting her claim is that during the pendency of the appeal, the provider will expect to be paid. And for someone who is of limited resources, this becomes a real problem. As Mrs. Bell said, she will probably have to take her husband home simply because of the uncertainty of the appeals process.

Our experience has led us to also come up with several suggestions that we think would go a long way to alleviating some of the problems that have been discussed by panelists today.

First of all, the interpretation of the need for posthospital care must be consistent. The intermediaries or the PRO's must be using the same definitions that are in law and should not be instituting their own informal oral provisions.

Second, health care professionals must finally realize that we have a problem that we share together, and then only together can we resolve these problems. We cannot think of hospitals or nursing homes as the enemy, but we must think of them as allies in search of some greater goal, which is consistent, good care for our senior citizens.

Third, consumers need to be aware of their rights. This is really an important function, I think, that we in Cleveland have accepted as the role of the Long-Term Care Ombudsman Program—though it is not clear to me that that is in fact our mandate. We have essentially had to educate ourselves on these issues with very limited resources and with no assistance from the Administration on Aging.

Finally—and this is the hardest of all to do—but over and over again, we have listened to the panelists tell us about their own particular catch-22 situations. There needs to be a coordinated system of health care delivery to our senior citizens. If we continue to implement policy changes outside the context of an overall health plan, we will continue to create more catch-22 situations.

To put it another way, as long as there are holes in the delivery system, there will be elderly citizens who will fall through them.

Thank you.

Chairman HEINZ. Reverend Hornbostel, thank you very much for some very good suggestions, a series of extremely pertinent observations. I am sure each member of the committee will want to study this in some detail, and I will urge them to do so.

[The prepared statement of Reverend Hornbostel follows:]

PREPARED STATEMENT OF REV. ROLAND HORNBOSTEL

INTRODUCTION

My name is Rev. Roland Hornbostel. I am Chief Complaint Investigator of the Cleveland, Ohio Nursing Home Ombudsman Program. The program is responsible for investigating complaints involving long term care facilities in a five-county area in Northeast Ohio which includes some 170 nursing homes with 17,000 residents. Our program also serves the residents of over 400 board and care facilities in the Cleveland area. In addition, over the years we have assisted many families in locating suitable placement in Cleveland area nursing homes and board and care facilities. Though not originally part of our mandate to investigate complaints about long term care facilities, the need of families for information about placement alternatives has become an important and time-consuming function of the Nursing Home Ombudsman Program. In the past year, we handled over 1200 requests for placement assistancce from families and friends of residents, from hospitals, and from community agencies.

Our involvement in placement assistance has lead to our growing concern about the effect of the hospital Prospective Payment System (hereinafter PPS), commonly referred to as the DRG system, on the residents and potential residents we serve. Our ability to work with potential residents and their families as they search out long term care resources has provided us with invaluable experience in evaluating the effect of the hospital PPS on the long term care delivery system, both in its institutional and its home-based delivery modalities. Our experience suggests that the typical family member does not call us complaining that they are the victims of a "DRG dump." Rather, the typical call is from a family member, usually quite panicked, saying, "I need help. The hospital says mother needs to find a nursing home within the next two days." For this reason, it is extremely difficult for us to quantify the number of individuals in need of long term care who have been adversely affected in their ability to find appropriate resources due to the advent of the hospital PPS. What follows, then, is our analysis of some of the negative effects of the hospital PPS on the lives of individuals in need of long term care. This analysis is informed by extensive contact with potential residents and their families, with nursing home administrators, with hospital discharge planners, with social workers from community agencies, and with heads of home health agencies. This analysis is also informed, in some measure, by research funded by the Villers Foundation, and conducted by the National Citizens Coalition for Nursing Home Reform. I have noted below those conclusions drawn from this national research project as opposed to those drawn from our own local experience in Cleveland.

I. NURSING HOMES ARE OFTEN ILL-EQUIPPED TO HANDLE RESIDENTS WHO ARE DISCHARGED "QUICKER AND SICKER" AS A RESULT OF THE HOSPITAL PPS

The institution of the hospital PPS by the Medicare program is a lead that has been followed by other third party payors such as Medicaid and private insurers in many states. At the heart of any prospective payment methodology is the existence of a powerful incentive to discharge patients sooner. The effect of this powerful incentive is positive if it results in a decrease in inappropriate hospital overstays. The effect is negative if it results in the discharge of unstable patients to nursing homes ill-equipped to provide the necessary services. Our experience suggests that, at present, hospital patients are being discharged to nursing homes and other long-term care settings that are not equipped to handle their increased care needs.

Though it is unlikely that a nursing home administrator or owner would come before this panel and state unequivocably that "I am unable to meet the increased care needs of these residents," these administrators and owners do talk to us. The picture they paint for us is one in which patients are discharged from hospitals with ever-increasing care needs that strain the existing resources of the nursing home to the maximum. Many nursing homes in the Cleveland area now have "quotas" of various types of residents. After the set quota is reached, the nursing home must refuse to admit more residents of the same type until a death or discharge occurs. This refusal will occur even if it means that a nursing home bed remains vacant as a result of the refusal. The type of resident for whom a quota is most likely to be instituted by the nursing home is one that has the heaviest projected need for care. Some common examples are residents who need to be tube fed, who need tracheostomy care, who need hyperalimentation, who need respiratory or extensive physical therapy, or who are on ventillators. It must be emphasized that these are nursing homes that are not intentionally trying to break federal laws in regard to the admission of handicapped individuals into federally-funded programs. These are nusing homes that do admit some residents of each type, but are unable to cope with the demand placed upon them by the hospital system while at the same time providing quality care to those residents who are admitted.

A second situation arises where a hospital patient is discharged to a nursing home or board and care facility needing care that a particular long term care facility has no capacity to provide. My first experience with a hospital PPS-related problem involved such a discharge problem. The resident was transferred from an Intermediate Care Facility [ICF] to the hospital for a leg amputation. The very next day, with no notice to the ICF, the resident was transferred back with orders for extensive physical therapy and rehabilitation services. Clearly, this resident should have been transferred to a Skilled Nursing Facility [SNF] as an ICF facility does not have nor is it required to have a physical therapist available for extensive rehabilitative services. I was able to convince the hospital of the need to transport the resident back to the hospital each day for therapy to resolve the conflict between the two facilities. However, the added expense of transportation charges as well as additional therapy charges seemed incongruous with the stated goal of the hospital PPS—cutting medical care costs.

More often, the problem of totally inappropriate placement will arise where a hospital, unable to find a nursing home bed for a patient, will discharge the patient to a board and care home. In Ohio, such facilities are not regulated or licensed beyond the requirement that they not admit patients in need of nursing care. Since the beginning of the PPS, we have visited a number of board and care facilities that have admitted patients in need of nursing care from a hospital. This problem has grown to such an extent that the Ohio Attorney General has announced a program to crack down on board and care homes that admit patients in need of skilled nursing care. Yet, this initiative treats only the symptom and not the underlying cause of the illness.

II. THE MEDICARE PROGRAM IS INCONSISTANT IN ITS COVERAGE OF THE HEALTH CARE NEEDS OF ELDERLY AMERICANS

Recently, it seems that some people have come to believe that the mission of the Medicare program is to control spiraling medical costs in the United States. However, I believe that there are still large numbers of individuals in this country who believe, as I do, that the mission of the Medicare program remains the same as it was when the program was created in the Sixties—to meet the medical needs of elderly Americans. Recent developments in Medicare reimbursement have created a "Catch-22" for many who are the beneficiaries of the program. At one hand, the hospital PPS seeks to curb unnecessary hospital overstays by rewarding hospitals for discharging patients at the earliest possible moment. On the other hand, we have witnessed an alarming increase in the number of denials of claims for Medicare SNF and home health benefits. Both the SNF benefit and the home health benefit were designed to allow patients to receive necessary post-hospital care in less expensive settings than hospitals—in nursing homes that were certified as Skilled Nursing Facilities, and in the patient's own home by certified home health agencies. These conflicting policies create a situation, which is sadly oft repeated, where patients are discharged from the hospital only to find that they are not entitled to extended coverage in a nursing home certified as an SNF and that if home care is indicated, Medicare will not reimburse the elderly individual for the staggering cost of such care. The effect is to create a health care delivery system that instead of providing a continuum of care to elderly individuals, instead provides only the empty promise of needed care while leaving the elderly to fend for themselves.

The existence of this very serious problem in not due simply to the Medicare claims review process conducted by the Fiscal Intermediaries as other commentators have suggested. In Ohio, the PRO (Peer Review Organization) since June of this year has undertaken, in addition to its responsibilities for the hospital PPS, the review of all claims involving SNF care or home health care that is Medicare reimburseable. Since our PRO has undertaken these post-hospital care review functions, we have witnessed a drastic reduction in the number of cases where SNF care under the Medicare program is approved. Particularly, our PRO has dramatically increased the number of denials of cases where an ongoing program of physical therapy is required. This increase has led more than one nursing home administrator to assert to me that: "In Ohio, the SNF Medicare benefit is dead." While the problem of increased denials was becoming a problem under the former procedure whereby claims review was conducted by the Fiscal Intermediary, the solution has not been found by simply substituting the PRO for the Fiscal Intermediary.

It should also be pointed out that while some may argue that this inconsistancy is saving the federal government's limited health care dollars, the reality is that many of these denials of SNF benefits result in the elderly patient's earlier eligibility for Medicaid benefits in a nursing home. As Medicaid is, in part (approximately 50 percent depending on the state), funded by the Federal government as well, such assertions of dramatic cost savings are exaggerated. Even worse, we have dealt with many cases where the denial of home health benefits has led to the costly forced institutionalization of elderly people whose care needs could have been met in their own homes.

III. ELDERLY CITIZENS DO NOT UNDERSTAND THEIR APPEAL RIGHTS UNDER THE PPS

The Medicare appeals process is very complex. Many professionals do not understand the rights of patients and their families to challenge the determinations made in regard to Medicare coverage. It is thus not to be entirely unexpected that the victims of premature discharges and faulty utilization review processes do not understand these rights either. Many elderly patients and their families have been content with such explanations as, "Your hospital stay is up under DRGs. You will have to make other arrangements for your father's care."

Even more complex is the program of understanding the process of appealing adverse Utilization Review findings in a nursing home certified as an SNF. A number of recent cases we have dealt with illustrate this problem. Mr. X enters a nursing home from the hospital. The nursing home calls the patient's wife to inform her that Medicare coverage will not be available to pay for her husband's stay at the facility because he does not need SNF care. At this point, the wife contacts us, stating, that "The nursing home wants me to pay them $80 per day for his care. The doctor assured me that it would be covered under Medicare." Formerly, we would instruct the wife to ask for a reconsideration, the first step in the arduous Medicare Part A appeals process. Imagine my surprise when the wife called me back and informed me that the nursing home had not even submitted the claim to the PRO.

When told by the nursing home that the wife was most insistant on having her husband's claim reviewed, the PRO instructed the facility to submit the claims form with the additional words: "At family insistance." While the wife in this case was ultimately successful in getting the nursing home to submit the claim, I question how fair the claims review will be where the claims form has been "red-flagged" with the words "At family insistance." The rationale behind the refusal of the facility to submit the claims form is complex and relates to an issue called "waiver of liability." Briefly stated, the problem is one where the nursing home will be retroactively denied reimbursement if its utilization review error rate exceeds a certain percentage of the claims submitted. In borderline cases, it is to the facility's advantage simply to not submit the claim at all.

Even if the wife successfully negotiates this stage of the process, she is faced with the prospect of having to pay the rate of the nursing home for SNF care, which in Cleveland can be as much as $70-100 per day, during the pendancy of the appeal. Many individuals we have dealt with have simply not had the private resources necessary to pay this high a price for the "luxury" of asserting their appeal rights. Instead, many choose to bring their relatives home, or move them to ICF facilities and apply for Medicaid.

IV. IMPLEMENTATION OF THE HOSPITAL PPS HAS EXACERBATED THE PROBLEMS OF MEDICAID DISCRIMINATION AND PLACEMENT OF HEAVY-CARE PATIENTS

One of the most significant findings of the research recently conducted by the National Citizens Coalition for Nursing Home Reform, which was funded by the Villers Foundation and in which I participated, is that since the implementation of the PPS, the problem of Medicaid discrimination has become worse. In addition, it has become more difficult to place patients with heavy care needs in nursing homes. Last October 1, this Committee conducted an excellent hearing on the plight of Medicaid recipients who sought to enter nursing homes only to be denied admission because of their Medicaid status. Sadly, the problem has grown worse since that hearing, in part due to the implementation of the PPS. The PPS has the effect of causing the discharge of Medicaid patients at the time when the care needs of these patients are the greatest, and therefore at the time when nursing homes are the most reluctant to admit these individuals. I cite this as a national problem and not as a local one due to the existence of two innovative state initiatives Ohio has used to combat these two problems.

First of all, Ohio has adopted strong anti-discrimination provisions in state law to protect Medicaid recipients from both transfer due to their Medicaid status and from discrimination in nursing home admissions policy.

Secondly, Ohio has adopted a case-mix reimbursement system under which nursing homes are reimbursed based on a formula that takes into account the individual care needs of nursing home residents, as opposed to an arbitrary system currently existing in most states where the nursing home is reimbursed based on the classification of a resident as SNF or ICF. In practical terms, what this means is that in Ohio (and in several other states as well) the nursing home is paid at a higher rate if it admits residents requiring more care. While this may seem at first to be a rather common sense approach, the vast majority of the states continue to reimburse based on the arbitrary federal classification system. Under the more typical system a nursing home is paid the same rate for admitting an ICF patient needing little care as it is for admitting ICF patient with heavy care needs—the very patient we are seeing more frequently as a result of the PPS.

Therefore, the effect of the PPS on the issues of Medicaid discrimination and admission for heavy-care patients is not as great in Ohio. However, the existing federal classification system of SNF vs. ICF has created problems in a state that no longer utilizes this outmoded methodology in its Medicaid reimbursement program. Currently, our organization is involved with 77 patients facing involuntary transfer from a SNF that has dropped its ICF certification. One reason given for the transfer of these residents is the fear that the Federal government will utilize its classification system to deny its share of Medicaid reimbursement for the care of these 77 residents despite the fact that Ohio no longer reimburses the facility based on this classification system.

A final factor that has contributed to the increase in Medicaid discriminaton since the onset of the PPS is the amount of vertical integration that has occurred in the health care system as a response to the PPS. What is meant by this is the propensity of hospitals to build, buy, or contract for beds in a nursing home. Many observers have concluded that such vertical integration is desirable in that it should improve patient care and continuity of care. However, one negative factor that needs to be closely examined in the future is whether hospitals will also discriminate against Medicaid recipients in admission to their long-term care beds. Early data suggested that in some areas of the country such discrimination is a problem already. The discharge planners of one hospital in Cleveland routinely call our program for placement assistance for their patients who are Medicaid recipients despite the existence of a contract between that hospital and a nursing home for a given number of beds.

V. SUGGESTIONS FOR IMPROVEMENT OF THE SYSTEM

While I am not a health planner, and certainly do not consider myself an expert qualified to solve the problems cited above, I am consistantly annoyed with individuals who are able to see only the problems and are not able to at least suggest possible solutions. It is in this spirit that the following suggestions are offered.

(a) Interpretation of the need for post-hospital care must be consistent.—The current problem of the hapless patient who no longer needs hospital care being informed, in effect, that Medicare will not pay for post-hospital care either needs to be addressed. This will occur only by ensuring that the PROs serve their function in cutting premature discharges from hospitals, while at the same time establishing the Medicare SNF benefit as more than a myth.

(b) Health care professionals must work together to ensure that the problem created by the PPS for individuals are dealt with.—While this seems obvious, for too long hospitals have regarded nursing homes as the "enemy" and vice versa. In Cleveland, if the Ombudsman program has been successful in any one activity, it is that we have been able to work out individual problems attributable to the implementation of the PPS through dialogue with nursing home personnel, hospital discharge planners, home health agencies, and social workers in community agencies. Such ongoing contact between professionals is essential in the early implementation stages of the PPS where problems and mistakes have occurred and will occur in the future.

(c) Consumers need to be aware of their rights.—Speaking as one staff member of a Nursing Home Ombudsman Program, it is clear to me that Ombudsman program staff have a duty to inform consumers of their rights both while in the hospital and following their discharge, as well as to assist consumers in the exercise of those rights. Essentially, we have, thus far, had to educate ourselves to the problems of individuals created by the PPS. With little direction from the Administration on Aging, we have tried to do the best we can with limited resources to alleviate the problems individual consumers bring to our attention. Many programs have now begun circulating brochures on the PPS, and are engaging in other activities to heighten public awareness to the problems created by the PPS.

(d) Creative utilization of health planning.—In Cleveland, our organization has been very active in working within the Health Systems Agency to ensure that the Health Plan developed for our area reflects concerns that have arisen with the implementation of the PPS. Creative use of Certificate of Need provisions can be made to ensure that nursing home beds are built by providers who will care for those individuals most adversely affected by the PPS.

(e) Federal enactment of Medicaid Anti-discrimination provisions.—This pervasive problem is attributable only in part to the PPS. However, this problem is one that literally cries out for federal initiatives in this area both to ensure that the Health Care Financing Administration enforces existing laws in relation to this problem and to enact new laws that will effectively ensure access for Medicaid patients who continue to overstay in hospitals *despite* the implementation of the PPS.

(f) Fair reimbursement for post-hospital care.—The present system of long-term care reimbursement is outmoded. Nursing homes should be reimbursed based on the actual care needs of the individuals they care for and the amount of care they actually deliver. This can only occur in the context of a case-mix adjusted system. In this regard, New York is currently preparing to implement a case-mix adjusted reimbursement system that utilizes much of the same methodology that underlies the hospital PPS while it takes into account the difference in services that are provided by nursing homes. The time has also come for the abolition of the Federal SNF-ICF classification system The more the long term care delivery system grows more complex, the more outmoded and simplistic this arbitrary classification system becomes. It is time for government to realize what health care professionals have known for a long time—there really are more than two types of nursing home residents.

(g) There needs to be a coordinated system of health care delivery to our elderly citizens.—This final suggestion is the one that in many respects is the hardest to implement. Without a coordinated plan for delivering health care to senior citizens,

though, we will realize that health care delivery must occur along a continuum that includes primary care, hospital care, and post-hospital care. If we continue to implement outside the context of an overall health plan, we will continue to create more "Catch-22" situations such as those mentioned above. To put it another way, as long as "holes" in the delivery system exist, there will be elderly citizens who will fall through them.

Chairman HEINZ. Let me introduce our last witness for the day, Ms. Hollis Turnham, who comes to us from Lansing, MI.

Ms. Turnham, we welcome you. I understand you too are going to summarize parts of your statement, and without objection, the entire statement will be a part of the record.

STATEMENT OF HOLLIS TURNHAM, LANSING, MI, STATE LONG-TERM CARE OMBUDSMAN, CITIZENS FOR BETTER CARE

Ms. TURNHAM. Thank you.

My name is Hollis Turnham, and I am the State long-term care ombudsman with Citizens for Better Care, and my office is in Lansing, MI.

I am very pleased to, as you said, very briefly talk about one problem that we have seen exacerbated by the DRG system. It is an old problem, and it has gotten worse with the implementation.

If you will remember, Senator, about this same time a year ago, this committee held a hearing about the access problems of Medicaid patients to nursing home care. One of those problems that was highlighted is the problem of nursing homes than demand private pay before accepting Medicaid. You followed up with a letter in December to local ombudsmen, asking us to look at that situation. You also expressed concern about the impending interplay of DRG's and the Medicaid access program.

We took to heart your request for additional looking at this, and we followed up on that. I am very sad to report that we have not seen much assistance at all from the Department of Health and Human Services in this issue, and I think we can document a failure of the Department to respond to those complaints.

Since your December letter, we filed 12 additional complaints in which we suspected that homes were violating section 1909(d) of the Social Security Act. We filed those with the regional inspector general's office, per your suggestion. Those complaints joined 22 others that were filed 3 years ago initially with the State and had been forwarded to the regional IG's office in Chicago.

None of our complaints have ever been acknowledged in writing. None of our requests for written information have ever been answered. None of our requests for status reports have ever been answered. We were willing to tolerate that based on oral promises made by IG regional staff that a presentation of that issue would be made to a U.S. attorney, and that we would be told of that presentation.

We learned from a letter that we obtained not from the regional inspector general's office that such a presentation was made to the U.S. attorney for the Eastern District of Michigan. The U.S. attorney for the Eastern District of Michigan refused to prosecute any cases under 1909(d), saying that because there was "no monetary loss to the Medicaid Program, that therefore, successful prosecution was highly unlikely."

The letter goes on to state that all future complaints filed would be forwarded instead to the attorney general for the State of Michigan.

The confusion mounts within the Inspector General's Office, because within the same week that the regional office was sending this letter to the Michigan attorney general, Inspector General Kusserow was responding to a request from the Michigan Senior Advocate's Council, and in the same week, he wrote them a letter saying, "Go ahead and continue to send your complaints to my regional office in Chicago."

We feel, Senator, that the nursing home residents, their families, and other advocates that we have been working with in a real concerted manner in the past year on this issue have been extremely poorly treated by the Inspector General's Office and the entire Department of Health and Human Services.

The interplay of the problems of Medicaid recipients finding a nursing home bed—you have already heard other panelists discuss the problems that beds are not even available for those people because they are trying and saving to get this elusive Medicare payment—and then, to try and treat those chronically ill patients, the basic patient, who you do not want to force into an unregulated board and care home or to a family situation where the family cannot cope with the situation of possibly a very small woman taking care of a 6-foot-tall man, has gotten worse. And I must say that we have not at all been pleased with the responses from the Department of Health and Human Services.

I do not know how you get those people to understand the issue. But I would certainly request that you and other Members of the Committee do everything to try and remedy that situation. Thank you.

[The prepared statement of Ms. Turnham follows:]

PREPARED STATEMENT OF HOLLIS TURNHAM

I am Hollis Turnham and am Michigan's State Long-Term Care Ombudsman [SLTCOP] with Citizens for Better Care [CBC], a 16 year old non-profit consumer organization concerned about the quality of care in nursing homes and board and care facilities. CBC is funded through Michigan Office of Services to the Aging to administer the SLTCOP.

I am very pleased to submit this written testimony to the U.S. Senate Special Committee on Aging with the views of the SLTCOP and CBC on the impact of the Prospective Payment System [PPS] called Diagnosis Related Groups (DRGs) on post-hospital health care.

There are three major items we consider very important to address.

(I) Medicaid eligible patients who need post-hospital care in a nursing home still face a form of extortion through the use of preadmission private pay contracts by nursing homes. Federal enforcement agency follow through since this Committee's October 1, 1984, hearing on this issue has not been encouraging.

(II) Level of care distinctions for nursing homes are outmoded and counterproductive to many new public policies and the reality of health care.

(III) Nursing homes are reporting it is impossible to care for the numbers and kinds of patients seeking admission since the implementation of DRGs.

PROBLEMS OF ACCESS FOR MEDICAID RECIPIENTS

In a December 1984, letter, this committee through Chairman Heinz sought the assistance of State and local Ombudsman projects in dealing with the horrendous problems facing poor, disabled individuals seeking nursing home care. (A copy of the December letter is attached to this testimony.) Because of the seriousness of these problems, the Michigan Ombudsman system has actively pursued the Medicaid access and DRG issues outlined in the December letter.

The committee's concern about the interplay of Medicaid discrimination and DRGs is being validated every day in Michigan. The inability of hospitalized older persons and their families to meet the monetary demands of a preadmission private pay duration of stay contract or to find a "decent" home willing to take a Medicaid recipient is responsible for untold anguish.

Unfortunately, we believe that there has been a failure on the part of the Federal enforcement agencies to respond adequately to our complaints about Medicaid access problems. Our problems are with the regional and national offices of the Inspector General [IG] of the Department of Health and Human Services [DHHS] and the U.S. Attorney's Office for the Eastern District of Michigan.

Since the Chair's December letter, Michigan's local Ombudsman projects have filed twelve (12) complaints with the regional IG's office in Chicago regarding illegal private pay duration of stay contracts. These 12 are in addition to the 22 complaints filed over three years ago with the Michigan Department of Social Services and later forwarded to the Chicago IG.

None of the complaints sent to the IG have ever been acknowledged in writing. Written requests for information and status reports on the complaints have gone unanswered. Offers of additional assistance to the regional IG are unanswered.

We were willing to accept those limitations in the work of the regional IG's office because of oral promises made by the IG staff. Those promises included that the Chicago office had been chosen to "spearhead" the national attack on illegal private pay duration of stay contracts. Regional IG staff also stated that a presentation of a case of illegal practice would be made to the U.S. Attorney's office for possible prosecution.

In a letter obtained by CBC from a source other than the IG, we learned that such a presentation was made. The attached letter dated August 1, 1985, from Assistant Regional IG Gerald L. Waroway to Michigan Assistant Attorney General (AG) Edwin Bladen reports on that meeting. The U.S. Attorney through Blondell Morey refused prosecution "because there is no monetary loss to the Title XIX program and that successful prosecution was, therefore, highly unlikely." The letter goes on to note that "all future violations of Section 1909(d)" will be referred to the Michigan AG.

We have two major complaints.

First, we strongly disagree with the analysis by the U.S. Attorney for the Eastern District of Michigan that a monetary loss is necessary for successful prosecution under section 1909(d) of the Social Security Act. For a more proper analysis, I have attached a copy of an April 29, 1983, memo from the IG to the Health Care Financing Administration [HCFA], we recently obtained. I would also point to the Committee's hearing report (S. Hrg 98-1091) which is crammed with thoughtful legal analysis of the enforceability of section 1909(D). Neither document mentions the necessity of monetary loss for successful prosecution.

Our second complaint is the conduct of the regional IG's office. The residents, families, and advocates we work with have been treated quite poorly by the IG. The August 1, 1985, letter by IG Waroway is not the first time our complaints have been "resolved" without notice to us or the complainants we represent. I have attached a copy of a letter dated April 23, 1985, from IG James Bailey to the head of Michigan's Medicaid unit. Again, the IG did not inform us of the actions taken regarding our complaints.

It appears that even the IG Richard P. Kusserow has not been informed of the actions of his Chicago regional office. Within the same week that regional IG Waroway was announcing the regional office's plan to send all private pay duration of stay contract complaints to the Michigan AG, IG Kusserow was advising the Michigan Senior Advocates Council to send the very same complaints to his regional Chicago office. There is obvious confusion within the IG offices as to the proper attention to be given these complaints. That confusion needs to be cleared up.

The failure and refusal of federal enforcement agencies to stop the practice of private pay duration of stay contracts means that a de facto policy of "family responsibility" exists in this nation. Attempts in the last two years by HCFA to secure state action to collect money from the families of Medicaid nursing home patients were stopped with the explanation that the Medicaid law had to be changed before such a program was legally enforcible.

Without Congress changing any statutes, the relatives and friends of poor, disabled people in need of nursing home care are now subsidizing the Medicaid program. Their contributions come in the payment of private pay rates for a time until the home agrees to accept Medicaid, accepting a bed in a substandard home that would otherwise close for lack of patients, or accepting services from something other than a nursing home and therefore relieving the Medicaid nursing home program from payment.

My sincere hope is that no person is simply going without any needed care because of the inaction of federal enforcement agencies.

LEVEL OF CARE DISTINCTIONS

Level of care distinctions for nursing homes are inflexible and unresponsive to new public health policies and the reality of health care. Currently, nursing homes and their patients are divided into two kinds. Skilled nursing facilities [SNF's] treat "skilled nursing patients." Intermediate care facilities [ICF's] care for those patients called "basic, custodial, or intermediate nursing" patients.

Although the vast majority of Michigan's beds are for both "skilled" and "basic" patients, approximately one-third of Michigan's homes can treat only "basic" patients.

PPS incentives for earlier discharge have increased the problems associated with the distinctions between "skilled" and "basic" care. While the distinctions may have some legislative reimbursement purpose, they have no basis in the real world of health care delivery. Nurses, physicians, and other health professionals are not trained in courses entitled "Skilled nursing care 101, 202, and 303" or "Basic nursing home care."

Strict enforcement of these reimbursement distinctions, particularly in the context of facility classifications, is fast becoming a major obstacle to quality health care for elders since the implementation of DRGs.

Two recent examples from Michigan are illustrative. Mrs. L., a 92 year-old women, had resided in a nursing home for 8 years. The nursing staff noted some disturbing conditions and recommended hospitalization. At the hospital, the nursing home staff's diagnosis of a collapsed and ruptured lung was confirmed. The necessary acute care procedures were performed and after 28 days of hospital care, the doctor said she ready to go back to the nursing home. The required Medicaid level of care evaluation forms were sent to the responsible state agency.

Mrs. L's level of care evaluation initially came back from that state agency as "skilled nursing", with an explanation that Mrs. L. would probably need only 5 to 6 days of "skilled nursing observation." Under the policies of PPS, Mrs. L. was supposed to be discharged because she no longer needed in patient hospital care. The only problem was that her home for 8 years was an ICF nursing home, not an SNF, as required by Medicaid reimbursement rules.

The ICF home refused readmission because of recent changes in the state's Medicaid policies which severely enforce the federal rule that "Medicaid will not pay for skilled patients to receive treatment in ICFs."

Despite the appeals of two of Mrs. L.'s attending physicians, the state level of care agency refused to change its evaluation of Mrs. L.'s care needs to "basic."

Mrs. L., who is also blind, is oriented to the ICF and it is her home. The family could have looked for an SNF placement for 5 or 6 days. But then the family would have had to continue paying to "hold her bed" at the ICF. (Since November, 1980, the Michigan legislature has refused to authorize Medicaid funding for "hospital leave days.")

But Mrs. L. stayed in the hospital until she progressed to the "basic" level and she "legally" returned to her ICF home.

The ICF's Director of Nursing aptly described the "craziness of the system." She pointed out that she and her staff were competent enough to recognize and diagnose the condition necessitating the hospitalization but were "deemed" not competent enough to handle 5 to 6 days of nursing observation during the convalescence.

A second Michigan case example does not have so pleasant an ending. In early March, 1985, a 69 year old Medicaid patient Mr. B was admitted to a rural hospital with a stroke from Nursing Home *X*. Mr. B's stroke was treated and he was ready for discharge. However, unlike Mrs. L's family, Mr. B. and his family did not have the resources to pay to "hold his bed" at Nursing Home *X* during the hospitalization so a new nursing home had to be found.

Such a home was found and in late March, 1985, Mr. B. was transferred to Nursing Home *Y*. But Nursing Home *Y* is an ICF without the physical therapy services Mr. B. needed. The state level of care evaluation agency came into the home two weeks after Mr. B's admission and classified him as a "skilled nursing care" patient.

Again because of the federal rule, "Medicaid will not pay for a skilled patient in an ICF," Nursing Home *Y* "strongly urged" the family to move Mr. B. as soon as possible. The family also wanted to find a home that could give Mr. B. the physical therapy services he needed and yet was close enough to allow family members to regularly visit.

In mid-April, Nursing Home *Y* found an SNF and therefore the physical therapy services needed by Mr. B. But the home was quite a distance from the family. With a threat that the family would have to pay unless Mr. B. was moved that day, the family agreed to the move to SNF Nursing Home *Z*. Mr. B was admitted to his third nursing home within a 60 day period. Mr. B. died in Nursing Home *Z* three days after admission.

But Mr. B's death has not ended the story. Nursing Home *Y*, the ICF which admitted a stroke patient directly from the hospital, is billing the family for the $798.00 for the cost of Mr. B's two week stay at the facility.

While some hospitals "game" the DRG system and level of care evaluations and some nursing homes exercise little or bad judgment on admissions, many elderly people are spending a lot of time in ambulances moving from facility to facility and from facility to hospital.

Both nursing home associations have advised their ICF members to secure a state sanctioned level of care determination before considering an admission from a hospital. Still others send staff to the hospital to evaluate the care needs of the person seeking admission rather than rely on hospital staff reports which are often inaccurate and/or self-serving.

CARE DEMANDS FACED BY NURSING HOMES

The reports we are receiving from nursing homes about the difficulties they face with the numbers and kinds of patients seeking admissions demand the attention of policy makers. While I cannot come forward with scientific data or analysis, I believe the "anecdotal information" calls for attention.

In evaluating the changing demands placed on her facility after the implementation of PPS, one nursing home owner explained that she took a long, hard look at her Director of Nursing [DON]. She believed that her DON was not professionally capable of handling the patients needs under DRG's . . . so she laid-off the DON. To secure a new DON that she felt had the professional skills to meet DRGs demands cost the facility an additional $4000 in salary along.

The major conclusion I reach after hearing such a story is to conclude that a very serious examination ought to be made of current staffing requirements in terms of number, training, and licensure status. Do we require enough licensed nurse coverage? Do we reqiure enough aids/orderlies to provide adequate and appropriate care? Have we mandated a sufficient amount of training for credit care staff?

Other facilities report demands for admissions for patients with different care needs than in the past and more patients with "heavier" care needs than provided in the past. One rural nursing home reports a 50 percent increase in the number of patients seeking admissions needing oxygen. The same facility was faced with the applications of three men seeking admissions after hip fractures. (While this diagnosis is quite common for women nursing home residents, it is far more infrequent to find a man with a hip fracture.)

Most nursing homes report an increase in applications for people using nasal-gastric tubes [NG tubes] for nutrition. Most facilities do not have an unlimited number of beds open for NG patients. They feel limited by the size and training of their staff, physical design of their buildings, and the number and kind of equipment available to the home for such feedings.

Intravenous treatments [IVs] often come up as problems for some nursing homes. IVs for chemotherapy and subclavian IVs which deliver total parenteral nutrition [TPN] present many nursing homes with problems. DONs express a reluctance to admit many or any such patients because of the size and training of staff and physical design of their building.

While it is undoubtedly true that some nursing homes are using DRGs as an excuse to continue to refuse admissions to patients with heavy care needs to save or make more profit, the issues raised by nursing homes need careful attention.

We also have concerns about the access problems of those people not needing oxygen or IVs or NG tubes. Nursing homes are clearly being asked to take on the more "skilled" patients out of hospitals. What has happened to those "basic" patients of old who used to get a nursing home placement. Have they been forced into board and care facilities which are incapable of meeting their needs? Are they being sent home without appropriate or sufficient in-home services?

If this nation's public policy has changed with DRGs to, in fact, place more demands on nursing homes and other segments of the long-term care system, we must insure that all segments of the continuum have the resources to meet that mandate.

In thanking the Committee for this opportunity to testify, I must close with the question of where do these people . . . Medicaid recipients, IV patients, "5 to 6 day skilled patients" . . . go for care? I hope that we are not so concerned about "the bottom line of cost containment" that we lose sight of the health care needs of our citizens.

Chairman HEINZ. Ms. Turnham, your testimony is extremely helpful. It is also extremely disturbing that after the very specific spotlight that we put—thank you for mentioning it—on this issue of conformance with and violations of conditions of participation under Medicare, that we are not achieving the goal, and the regional inspectors general are not following through—well, maybe they are following through, but the U.S. Attorneys in various districts appear not to be doing their job. I thank you for bringing that to our attention.

I would like to ask you and Rev. Hornbostel a question. As you know, Congress reauthorized last year the Older Americans Act, adding a requirement that the Commissioner coordinate with the PROs. I expect that that would mean the administration on aging would be coordinating your offices with the PROs.

How has that collaboration, if any, been going between the PROs and the ombudsmen?

Ms. TURNHAM. To the best of my knowledge, Senator, I cannot think of any direct collaboration between the administration on aging and the PRO, but for the regional offices sponsoring a training, and I know at one point, we were discussing putting the MPR issue on that training.

The other issue that concerns me about the MPROs and the way that we are interrelating with them is that our program has assisted families in filing directly complaints to the Michigan MPRO, which we call the MPRO, complaints about hospital care. We and the families that we help have been very disturbed about what happens to those complaints.

The PROs tell us that all that they can tell us and the family members after they have completed an investigation is, "Yes, we got your complaint." That is it. That is to be compared when we file a complaint against a nursing home in the State of Michigan, we get a call before the investigators go out, we get a call after the investigators come back, we get a copy of the investigative report, we get a copy of the sanctions, of the citations. We can challenge the sanctions that are imposed upon that nursing home, and we can take that to hearing, and we can ultimately take that into court.

When we file a similar complaint about hospital treatment with the MPRO, all we get is a letter saying, "We got your complaint."

I know that one of those families that we have been assisting through this has submitted to the committee some correspondence relevant to that transaction, and I would like to formally submit that and make that a part of the record. The MPRO responds that those are the Federal regulations, that they cannot tell you what has happened. And the families that we deal with want that issue addressed.

Chairman HEINZ. You are saying that the confidentiality regulations are a barrier?

Ms. TURNHAM. Yes, sir—are a total, complete barrier. They will not even tell you if they have completed an investigation; if anything was found wrong, if any remedies were taken. All you get is an acknowledgment, "Yes, we got your complaint, and please be assured we are doing everything to remedy it."

Chairman HEINZ. Rev. Hornbostel, do you have anything you want to add to that?

Reverend HORNBOSTEL. Yes; I would just like to add, Senator, that I am distressed because I did not know until I was sitting here that the administration on aging was supposed to be coordinating our activities with the PRO. I think that is probably indicative of another problem.

I will say that we in Ohio have felt it very important to be in contact with our PRO because our PRO, unlike that of other States, is now doing all Medicare reviews, including those for the skilled nursing facility and home health care benefits, which makes us a little bit unique.

And so far, the only complaint I would have is that mentioned by Hollis, that confidentiality requirements are being interpreted so strictly that our PRO will not even talk to families about individual cases.

Chairman HEINZ. One other question for you both.

We have gotten a lot of testimony in the last month about how some of the shortcomings of the some 470 DRG classifications and how those create problems for Medicare beneficiaries at the hospital level.

Under Medicaid, we have got a two-tier, two-classification system. Is there anything better in use at this time that either of you know of that would work better than the present system? We know that the 470 categories really leaves a lot to be desired and is not sufficiently sensitive to the problem, particularly of the older elderly, the sicker elderly; it creates incentives that are quite dangerous, in fact.

Are we facing the same thing with respect to Medicaid nursing home reimbursements here, and is there anything we can do about it, or do we know of any better models than what we have got?

Reverend HORNBOSTEL. I think that that is a very perceptive observation on your part. The distinction between skilled and intermediate is so artificial that in one State, perhaps 3 or 4 percent of the patients are considered to be skilled, and in another State perhaps 70 to 80 percent of the patient population is considered to be skilled.

I cannot believe in this country of great geographic diversity, that that has caused that much diversity in terms of the amount of care people need in nursing homes.

The only purpose that the distinction between skilled and intermediate continues to serve is that of serving as an effective bar to admission of Medicaid patients to nursing homes, and for that reason, I think it would be important to consider, as I believe forthcoming studies will also suggest, that level of care be abolished and that something better be instituted in its place.

As to the "something better," I also feel very strongly that presently, there are six States that have either implemented already, or are preparing to implement, reimbursement methodologies for their Medicaid nursing home benefits that take into account the individual needs of residents. Instead of giving one rate for skilled patients and one rate for intermediate care patients, the facility gets a blended rate based on the amount of care they deliver to the type of patients they admit. I believe that is a much more fair and workable system for the nursing home, and it ensures access to those residents needing most care.

Chairman HEINZ. Thank you. That is very helpful.

Is there anything you wish to add to that, Ms. Turnham?

Ms. TURNHAM. I would simply add, Senator, that we continue to see the problems with level of care. We have one case in which a person was bounced between three nursing homes and one hospital within 60 days because of the interplay of these level of care distinctions, skilled nursing facility versus ICF, and the problems of holding a bed during a hospital stay.

Another thing that might be considered is simply, while you may want to keep a reimbursement distinction between skilled and basic, there is certainly no rationale for distinguishing between facilities. If a nursing home is going to be a nursing home, let us have it be a nursing home, and that people can be admitted without these artificial distinctions that are made in many contexts, certainly in certification but also in licensure, and that people do not have to be trundled around and spending too much time in ambulances, finding an appropriate care position.

Chairman HEINZ. We had some very good testimony giving us additional case histories on these very issues earlier.

Mr. Dombi, let me ask you this. In your testimony, you charged that the Health Care Financing Administration was illegally circumventing the intent of Congress. Can you prove that?

Mr. DOMBI. We have a number of times, both in district court and before administrative law judges. But I will leave the judgment up to you on this one example that comes to mind, and that is again having to do with the part-time or intermittent definition. The intermediary decided to impose a stricter definition than had been imposed before and decided in determining whether an individual was entitled to payment for part-time or intermittent home health aide services, they would look at the level of care also provided by family members. And when you combine the family-provided service with the agency-provided service, if it totalled 7-day-a-week care, no coverage was granted at all.

Chairman HEINZ. Do you want to—I heard it, but I think just for the record, it needs to be restated. What you have just described is that in an effort not to pay a legitimate benefit where intermittent care was being delivered—intermittent care is reimbursable under Medicare—the intermediary, or HCFA, said what you will do is count not only the care of the home health aide who comes 2 hours a day, 3 times a week, but you will count the care by family members, and if that becomes in effect full-time care, you will deny reimbursement.

Is that what you just tesified to?

Mr. DOMBI. That is correct, Senator. And an aide service is such a simple service as getting a glass of water to swallow a pill, which is the assistance with the administration of oral medication, and virtually anyone who meets the homebound requirement is going to have to have that kind of service provided to them daily. We had an individual whose husband had Lou Gehrig's disease. She chose not to fight the case. She chose to try and make it on her own, providing 24-hour, nonsupported services to her husband. I think there are two victims of that disease right now.

Chairman HEINZ. Well, you have been extraordinarily helpful, all three of you, and indeed our entire set of witnesses today have really helped to illuminate the numerous problems that the Medicare beneficiary faces once he or she is discharged from the hospital.

Our previous hearing made it clear that people are being discharged inappropriately, sicker, quicker. Now what we are finding, thanks to your testimony and that of the people who preceded you, is that there is a massive number of additional individuals who need home health care, who need the proper nursing home care. There is, however, a maze of regulations, a series of stumbling blocks and roadblocks to their getting appropriate treatment or reimbursement for that treatment. The net result of all of this is that people who think themselves extraordinarily well covered because they have got Medicare, because they have got private health insurance, because they have got an entire range of abilities—they think—to pay for this, in fact, are not only out on a limb, but finding it sawed off, and they are falling to the cold, hard ground beneath.

This is the second problem with DRG's. What happens after DRG's leave the Medicare beneficiary high and dry and out of the reach of appropriate health care.

It is this Senator's view that it is all well and good to have a more efficient health care payment system, but we must recognize that if the incentives in that system are to result in the earlier discharge of patients who for the sake of argument could be properly cared for in other than an acute care or hospital setting, that we simply cannot say, "Fine. The rest of the health care system is up to the job," and we can just take all of that money, put it in our pocket, and be done with it. We have to make an investment of a portion of that savings in the other kinds of health care that are going to be needed if we discharge people more rapidly. It is common sense. It stands to reason.

What we are seeing, instead of an appropriate liberalization, fine-tuning, greater attention to, more support for home health care and nursing home care, what we are actually seeing is a tightening of the eligibility, a squeezing of the regulations so that that care is harder to get. Indeed, what we are seeing is a series of totally irrational decisions being forced on people, where technicalities are the basis for judging care. I thought one of our witnesses who described one of the bases for eligibility as, it is a question of whether you stick a needle in a patient or have a catheter, that that is really all there is to skilled nursing care and if it is a matter of actually having someone skilled who can observe whether the patient needs any of those things, that is not skilled nursing care, and therefore, sorry, that person or that facility is ineligible. This really just about summarizes the kind of mindset that is prevalent at the Health Care Financing Administration, the Health and Human Services Department, and the Office of Management and Budget—which is, we are going to squeeze every dollar out of Medicare, and we just do not care what happens to people.

Well, this is one Senator and this is one committee that I think very much does care what happens to people. And we are going to continue to focus the spotlight on this issue in the same way that this committee, reaching perhaps just a little bit beyond its jurisdiction, did for 2½ years in the case of disability reviews under Social Security, years until we finally illuminated the truth.

This is not an issue that is going to go away. We are trying to nip it in the bud, we are trying. We are, frankly, not getting much help from the people downtown incidentally, whose salaries are paid by the Medicare beneficiaries and their families, who contribute each week, each bimonthly pay period, to the Medicare Program. The people whose salaries are being paid are in the process of making life miserable, deadly, for tens of thousands of loved ones and the Medicare beneficiaries.

That is not what we intend to put up with, and we are going to do something about it. We are going to just keep turning up the lights until the light, if you will, generates enough heat so that something gets done. And we are going to look at all of the other avenues legislatively to do something about it.

So I thank you all very much for being part of this process.

Our hearing is adjourned.

[Whereupon, at 12:30 p.m., the committee was adjourned.]

MEDICARE DRG'S: THE GOVERNMENT'S ROLE IN ENSURING QUALITY

TUESDAY, NOVEMBER 12, 1985

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The special committee convened, pursuant to notice, at 9:30 a.m., in room SD-628, Dirksen Senate Office Building, Hon. John Heinz (chairman) presiding.

Present: Senators Heinz, Chiles, Bingaman, and Dodd.

Also present: Stephen R. McConnell, staff director; Robin L. Kropf, chief clerk; James Michie, chief investigator; David Schulke, investigator; Beth Fuchs, professional staff member; Lucia DiVenere, professional staff member; Leslie Kramerich, professional staff member; Isabelle Claxton, communications director; Sara White, communications deputy; Diane Lifsey, minority staff director; Jane Jeter, minority professional staff member; Kimberly Kasberg, staff assistant; Diane Linskey, staff assistant; and Dan Tuite, printing assistant.

OPENING STATEMENT BY SENATOR HEINZ

Chairman HEINZ. The committee will come to order.

Although our first witness will be Eleanor Chelimsky, the Chair would like to inquire as to whether Mr. McClain Haddow is present for the purpose of submitting documents in response to a committee subpoena?

[No response.]

Chairman HEINZ. Very well. We will proceed.

This committee today convenes for the third time to hear testimony on the impact of the administration's new Medicare cost containment program, DRG's, diagnosis-related groups—on the quality of health care afforded 30 million older Americans.

It is a sad state of affairs indeed when the U.S. Congress has to resort, as you will see in a minute, to a subpoena to obtain information due it under law from an agency of the executive branch.

Unfortunately, this morning's exchange reflects an established pattern of withholding and misrepresentation of information by the Health Care Financing Administration. When asked to respond to reports of substandard care under the DRG's, agency representatives spoon feed us their so-called truths in dribs and drabs. We are expected to buy these truths on faith alone without the documentation behind them.

Well, as a Member of the Senate and as chairman of this committee, I for one have lost all faith in the garbled, incomplete mishmash of information and misinformation held forth as fact by the Health Care Financing Administration.

The facts, as reported by this committee, facts well-documented through hearings and a 4-month investigation, are indeed clear.

First, built into the DRG's are incentives to compromise high-quality care and to maximize profits.

Second, symptoms of program abuse riddle every level of care from hospital to nursing home to home health.

And finally, the watchdog peer review organizations feel hamstrung to identify and sanction even the worst offenders.

Juxtaposed against this national scenario of suffering, frustration and greed is a graveyard silence from the halls of the Health Care Financing Administration. Acting Administrator Haddow, who I am informed has just arrived, and I see him seated in front now, refers to anecdotal episodes of abuse, assuring Congress and the American public that no systematic problem exists.

Webster's Dictionary defines "anecdote" as a short account of an interesting or amusing incident. Now, to my mind, when a 68-year-old man discharged prematurely dies on his way home from the hospital, or when a 71-year-old blind woman with a pacemaker is discharged to her home alone, with no one to care for her, the incident is far from amusing. It is tragic.

How many anecdotes it will take for the administration to justify further expenditures on quality review and enforcement is anybody's guess. Do we need a body count in the tens of thousands to elevate the crisis beyond an anecdotal status? How many voices must be heard, what abuses observed to gain consensus on the need for some reform?

A third committee staff report,[1] for release this morning, summarizes the eight major quality problems under DRG's and the administration's position on each. Too often, administration rhetoric is the antithesis of committee facts, with reassurances based on what the watchdog PRO's, or peer review organizations, themselves call a restrictive, underfunded, relatively inflexible and too narrowly focused program of health care review.

We do anxiously await the administration's testimony today. Reforms, in my judgment, must be made in the program, and the simplest, most effective way is through joint legislative/executive initiatives.

But let the administration stand forewarned. We will schedule more hearings. We will broaden our investigation. We will introduce legislation. We will do what it takes to assure Medicare beneficiaries the high quality of health care that they have paid for and which they have every right to anticipate.

Since Mr. Haddow is here, there is a first order of business this morning that we do need to attend to, and that is for the committee to receive certain documents and materials demanded of C. McClain Haddow, the Acting Administrator for the Health Care Financing Administration, in a committee subpoena served on him at his office on November 8, 1985.

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[1] See p. 361.

Mr. Haddow, would you please take a chair at the end of the witness table for a moment, please?

Mr. Haddow, the subpoena served on you last Friday seeks the following items from you as Acting Administrator of the Health Care Financing Administration: First, the draft or final reports to the Congress concerning the impact of the prospective payment system and mandated by Public Law 2821, section 603(a)(2)(a) and 605(b). These two reports were to be submitted to the Congress by December 1984 and December 1983, respectively.

No. 2, copies of eight grant proposals generated by your agency, the Health Care Financing Administration, and offered to certain peer review organizations for the study of quality of care issues in Medicare and in the administration of the prospective payment system. The subpoena also seeks any and all correspondence, memoranda, and other records pertaining to the eight grant proposals.

Mr Haddow, are you prepared at this time to comply with the subpoena and to produce these documents and materials?

Mr. Haddow Yes, sir.

Chairman HEINZ. Very well, Mr. Haddow. Are these the materials, to my right?

Mr. HADDOW. They are, Mr. Chairman.

Chairman HEINZ. Very well. The hearing clerk will receive the materials from you. I thank you very much for complying with the subpoena, and you are excused until it is your turn to present your testimony later this morning.

Mr. HADDOW. Thank you, Mr. Chairman.

Chairman HEINZ. Thank you, Mr. Haddow.

Senator John Glenn, the ranking minority member of this committee, and Senator Larry Pressler cannot be with us today because of prior commitments. They have, however, submitted statements for the record, and without objection they will be inserted at this point.

[The statements of Senators Glenn and Pressler follow:]

PREPARED STATEMENT OF SENATOR JOHN GLENN

As the senior Democratic member of the Senate Special Committee on Aging, I have been pleased to participate in the Committee's review of Medicare's new Prospective Payment System (PPS), based on Diagnosis Related Groups (DRGs). Today's hearing is the Committee's third look at quality and access to appropriate care under DRGs, in both the hospital and post-acute setting. Its purpose is to unify the Committee's findings into public policy statements.

Mr. Chairman, I look forward to working with you and other members of this Committee in pursuing bipartisan initiatives to fine-tune the Medicare DRG system. However, I know of no legislative or administrative action that would be more important to our nation's Medicare beneficiaries than stopping the Administration's budget-cutting axe.

The Aging Committee must take the lead in fighting Administration cuts in Medicare protection. The fact is that the Committee's last two hearings have highlighted actions by the Administration that reduce patients' access to benefits. These have been "back-door" benefit cuts. Rather than being made through legislative proposals or formal regulations with comment periods, they have been made indirectly through instructions to fiscal intermediaries and directives to Peer Review Organizations.

For example, the Health Care Financing Administration (HCFA) has directed the watchdog agencies of DRGs—the Peer Review Organization (PROs)—to concentrate on rigid cost containment objectives while quality-of-care safeguards sit on the back-burner. The PROs have not been given the budget, guidelines and authority to do both jobs as called for by Congress in the 1983 legislation which created them. Fortunately, we are now well on the way to enacting legislation to increase the PRO's operating budgets and to further spell out their quality-of-care responsibilities.

Moreover, when Medicare patients are leaving hospitals "quicker and sicker" under DRGs, skilled nursing benefits, home health services, and hospital discharge planning under Medicare are needed like never before. "Quicker and sicker" in and of itself is not a problem if acute hospital care is no longer needed. However, alternative forms of appropriate care-giving must be available. And, what we found out at our last hearing is that when quality post-acute services are available, too often Medicare will not pay as a result of Administration-initiated crackdowns in skilled nursing and home health benefits. Moreover, in some communities, adequate post-acute care is in short supply.

Active advocacy is needed to ensure that Medicare beneficiaries understand their rights to medical care under DRG's and to see that those rights are protected. We must strengthen our national Ombudsman program and make its more widely available. I look forward to working with Committee members in promoting this advocacy. And, as we have in the past, I look forward to working together to blunt the blows of the Administration's budget axe.

Statement of Senator Larry Pressler

As you know, this is our third and final hearing on the impact of DRG's on the quality of care. I am pleased to see that this hearing gives the Administration a chance to respond to our findings during the two previous hearings.

In many ways, the new Prospective Payment System (PPS) is working. Blatant abuses in the Medicare system are being abolished. Thus, our goal of containing costs in being met. However, this committee has found numerous instances where cost containment is being achieved at the expense of quality care. We have heard of tragic human cases where quality care was completely denied. This simply cannot be allowed to continue. Specific problem areas which must be addressed include:

(1) Informing patients of the Medicare appeals process. Patients are not aware of their right to appeal. As we discovered at the hearing in October, there is very little knowledge of the ombudsman program, and there seems to be little or no effort to make it more widely known.

(2) Revising reimbursement rates for rural hospitals close to urban areas. This is a primary concern of mine. These hospitals are receiving lower reimbursements although they must compete with nearly large-city hospitals for the same doctors and nurses. Their wage index is equally high, and in many cases their costs are greater.

(3) The Health Care Financing Administration's (HCFA) continued denial of quality of care problems under PPS. Congress, and this committee in particular, have spent a great deal of time examining this issue, and have repeatedly found major problems. Yet, HCFA maintains there is "no significant problems."

(4) Particularly disturbing is the inability of the Department of Health and Human Services to produce Congressionally mandated reports on the impact of PPS and DRG's. Specifically, two reports were mandated by Congress—one due in December of 1983, and the other in December of 1984. Neither report has been completed.

The implementation of the Prospective Payment System, with its DRG has solved some problems, and created others. We must now act to close up the "quality of care loopholes", which I firmly believe exist. Cost containment and high quality health care can and must co-exist.

Chairman **Heinz**. As I noted at the outset, our first witness is Eleanor Chelimsky, the Director of Program Evaluation and Methodology Division of the General Accounting Office.

Please proceed.

STATEMENT OF ELEANOR CHELIMSKY, DIRECTOR, PROGRAM EVALUATION AND METHODOLOGY DIVISION, GENERAL ACCOUNTING OFFICE, WASHINGTON, DC, ACCOMPANIED BY DR. JILL BERNSTEIN, PROJECT MANAGER; DR. ERIC PETERSON, AND DR. ROGER STRAW

Ms. CHELIMSKY. Good morning, Mr. Chairman.

It is a pleasure and a privilege to be here this morning, and we thank you for inviting us. Let me begin by introducing the people who are here at the table with me.

First, on my left is the Project Manager for our study on "Information Requirements for Evaluating the Effects of Medicare's Prospective Payment System on Post-Hospital Care," and that is Dr. Jill Bernstein. We also have Dr. Eric Peterson and Dr. Roger Straw, who have taken major parts in the study as well. And I want to introduce Dr. Lois-ellin Datta, who is my Associate Director for Human Services Evaluation back there somewhere, who is with us today.

Chairman HEINZ. Very well.

Ms. CHELIMSKY. We wanted to bring you up to date on the progress we have made in our study, and I thought it would be as well to simply summarize the highlights of the testimony that you have and ask if you could put the full statement in the record.

Chairman HEINZ. Without objection, the full statement will be a part of the record.

Ms. CHELIMSKY. Thank you, Mr. Chairman.

I wanted to make two basic points today. First, we think it is indeed feasible to conduct studies which can demonstrate the effects of PPS on posthospital care. We have identified and technically specified two approaches which can be used to inform the Congress about the effects of PPS on Medicare services and on Medicare beneficiaries.

Second, the Department of Health and Human Services, HHS, is not currently doing studies that will produce this type of information. What this means is that at the present time, HHS does not have an adequate basis for concluding that PPS affects or does not affect posthospital care.

Further, the work underway in this area is so extremely limited that it is unlikely to yield information supporting such conclusions in the near future. As you may remember, Mr. Chairman, this committee requested GAO to answer a number of questions about PPS and posthospital care.

What, you asked us, were the most important issues in thinking about the effects of PPS on patients and on their health care after they left the hospital? Well, based on onsite reports, expert opinion and prior research, we identified five key issues.

First, the issue of patient condition at hospital discharge. To evaluate PPS's effects on posthospital care, you have to know what happened to patient condition as a result of PPS and the earlier release from hospitals that PPS could engender. This is not just crucial information in itself. It is also an indicator of change in the need for posthospital services. Are patients better off? Are they worse off? Are they the same? Obviously, if they are better off, they are going to need less posthospital care, but if they are worse off, they are going to need more.

The second key issue was what, in fact, happened to the use of posthospital services like nursing home care and home health care. Are these used more now as a result of PPS? Are they more crowded? Are they used differently than they were before?

The third issue was what about expenditures for these services. Since Medicare PPS was supposed to reduce costs in the hospital component of the health care system, it was important to find out whether it did not also increase costs in the posthospital component of that system, in which case, of course, savings identified would be more apparent than real.

The fourth key issue was access. We had shown in our 1983 Report on Nursing Homes that already at that time, there were major problems of access to nursing homes for elderly patients requiring extensive services. So if the use of posthospital care did increase as a result of PPS, how would that affect already constrained access to nursing homes?

The last issue, but definitely not the least of the five, was quality. What happened to the quality of care delivered by posthospital providers as a result of PPS?

All of these issues are important in determining the effects of PPS on posthospital care, but we knew that some of them might well pose problems of measurement and data collection, and this was the next question you asked us to look at.

For example, there is not a lot of agreement about how to measure precisely either patient condition at discharge or quality of care.

Further, to determine how, say, quality of care after PPS might differ from what it was before PPS does not just mean having valid measures. It means being able to collect data on these measures and having baseline data available that date from before October 1983 when PPS was implemented.

So we examined what it would take in terms of design, in terms of measures, in terms of data, to find out whether circumstances had changed since PPS with regard to our five key issues, and we also went one step further. We looked at what it would take not only to establish whether changes had occurred since PPS, but whether those changes were attributable to PPS and not to something else, such as a general aging of the population or new technology or some other thing.

Today, we report on our findings and on the evaluative information that can be produced.

Let me make two points here. First, of the five key issues, use and expenditures are clearly the easiest to evaluate. In our report, we lay out a way of doing this via an interrupted time series design that is comparatively inexpensive because it uses already existing administrative data. You can see what kind of information would be available using this design from the first chart we have prepared up there, showing information obtainable from Medicare administrative data. This is also exhibit 1.

EXHIBIT 1

Can Information on the Effects of PPS on Post-Hospital Care Be Obtained from Medicare Administrative Data?

Outcomes	From existing and validated measures?	If existing measures are validated?	With the development of new or better measures?
Patients' condition at discharge	- No	- No	- No
Use	Yes, on - Number of users - Volume of services	- Nothing additional	- Nothing additional
Expenditures[a]	Yes, on - Expenditures per patient - Expenditures per episode of illness	- Nothing additional	- Nothing additional
Access	- No	- No	- No
Quality	Yes, on - Readmissions[b] - Mortality[b]	- Nothing additional	Yes, on - Inappropriate types or amounts of care[c]

[a] Based on interim bills that may not exactly equal, in sum, the total of Medicare expenditures.

[b] From SNFs or HHAs within specified periods of time.

[c] For example, physician or outpatient clinic visits under Medicare Part B.

EXHIBIT 2

Can Information on the Effects of PPS on Post-Hospital Care Be Obtained From Data Abstracted From Medical Records?

Outcomes	Using existing and validated measures?	If existing measures are validated?	With development of new or better measures?
Patients' condition	- No	Yes, on - Physical condition at hospital discharge	Yes, on - Need for post-hospital care at discharge
Use	Yes, on - Number of users and volume of services for Medicaid[a]	- Nothing additional	- Nothing additional
Expenditures	Yes, on - Expenditures paid by Medicaid[a]	- Nothing additional	- Nothing additional
Access	- No	- No	Yes, on - Use rates of post-hospital services by patients in need of care[b]
Quality	-No	Yes, on skilled nursing care on - rates of recuperation - avoidable complications - appropriate treatment plans	Yes, on home health care on - rates of recuperation - avoidable complications - appropriate treatment plans

[a] Appropriate data on use and expenditures from other sources (e.g., state funds or out-of-pocket) are probably not available.

[b] Assuming that a valid and reliable measure of need for post-hospital care can be developed.

EXHIBIT 3

What HHS Studies Address PPS Effects on
Post-Hospital Subacute Care Services,
and What Will They Cost?

Study description	Status	Estimated extramural cost
Basic activities		
1984 annual report to Congress (HCFA)	Not released 10/15/85	Intramural
1985 annual report to Congress (HCFA)	Due 12/31/85	Intramural
1986 annual report to Congress (HCFA)	Due 12/31/86	Intramural
Brandeis University Health Policy Research Consortium (HCFA)	Ongoing March 1984 to February 1989	$1,375,000
RAND/UCLA Health Financing Policy Research Center (HCFA)	Ongoing March 1984 to April 1989	$1,525,000
Descriptive surveys		
National Long-Term Care Survey (ASPE/HCFA)	1982 data collected 1984 data collected, analyses	$975,000 $1,800,000
National Nursing Home Survey (NCHS)	1977 data collected 1985 data being collected	$1,100,000 $5,300,000
National medical expenditures surveys		
NMCES (NCHSR)	1977 data collected	$23,700,000
NMCUES (NCHS/HCFA)	1980 data collected	$19,550,000
NMES (NCHSR/HCFA/NCHS)	1987 data collection planned	Figures not available

(EXHIBIT 3 cont.)

Study description	Status	Estimated extramural cost
Change-over-time studies		
National Home Health Study (HCFA/BQC)	Results released 3/85; no written report	Intramural
National SNF Study (HCFA/BQC)	In planning	Intramural
Beneficiary Profiling System (HCFA/BQC)	In progress, scheduled completion 1986	Intramural
Comparison of the Cost and Quality of Home Health and Nursing Home Care Provided by Freestanding and Hospital-based Organizations (HCFA/University of Colorado)	1980 and 1982-83 data collected 1986 data to be collected scheduled completion December 1986	$1,579,000
Hospital Cost and Utilization Project (NCHSR&HCTA)	1970-77 data collected 1980-87 being collected 1980-84 patient and hospital files, scheduled late 1986	Intramural
Impact of the PPS on the Quality of In-patient Care (HCFA/Commission of Professional and Hospital Activities)	Scheduled completion late 1988	$145,000
Medicare Quality of Care Study (RAND)	Scheduled completion late 1988	Figures not available
Attributive studies		
Selected Analyses of PPS Impact on Hospitals' Behavior (HCFA/Urban Institute; Georgetown)	Scheduled completion early 1987	$480,000
Evaluability Assessment of the Medicare PPS of Long-Term Care (ASPE/Urban Institute);	Scheduled completion fall 1985	$130,000
Assessing Post-Hospital Discharge Behavior Feasibility Study	Scheduled completion late 1986	$135,000

EXHIBIT 4

Will Information Be Available From Ongoing or Planned HHS Evaluations on Post-Hospital Outcomes?

Outcome	Attributive	Change-over-time	Descriptive	Measurement development
Patients' Condition	No	Limited[a]	Limited[a]	Limited
Use	Limited[b]	Yes	Yes	NA
Expenditures	No	Yes	Yes	NA
Access	No	Limited[c]	Limited[c]	No
Quality	No	Limited[d]	Limited[d]	Limited

[a] Only on a few medical conditions.
[b] Only on changes in hospital provision of post-hospital services.
[c] Only on proxy measures for access.
[d] Only on readmissions and mortality.

If you look at the exhibit or the chart, you can see that using the interrupted time series design, you would get information showing the effects of PPS on posthospital use and expenditures. You would also get a little bit of information on quality, but rather gross and crude.

I wanted to mention also that obtaining these data would be greatly facilitated by completion of the MADRS [Medicare Automated Data Retrieval System] system currently under development at HHS.

My second point is that by using medical records—not administrative records here, but medical records—and a nonequivalent control group design, the much more difficult issues of patient condition, access and quality can also be evaluated.

However, this would be a fairly expensive strategy because it involves a lot of original data collection and also the development of measures for these issues.

Although this work would be expensive, as I say, it is certainly not out-of-line compared to other HHS research expenditures. I draw your attention, Mr. Chairman, to exhibit 3.

Our second chart up there shows the information that can be abstracted from medical records. That is exhibit 2.

Here, you can see that we can not only get information on the use and expenditure effects of PPS, but also on patient condition and quality of care. The issue of access seems to be the most difficult one to evaluate in that we are forced to await the development of some new measures. However, we believe these can be developed.

So, to make a long and rather technical story short, our study will show that it is feasible to evaluate the impacts of PPS on Medicare beneficiaries and services.

Let me now turn to answering the committee's last question which was, what is HHS doing to determine those impacts.

Here again, you need to look at exhibit 3 and exhibit 4, the third chart we have prepared which explains the information that will be available from HHS' study.

Now, exhibit 3 shows that much research is going on at HHS. But exhibit 4 makes clear that HHS has not done and does not currently plan to do the types of attributive studies which would produce valid information about the effects of PPS on posthospital care. If you look at the attributive column in the chart, or in exhibit 4, you can see that for four of the five key issues, the answer that you have to give as to whether attributive information is going to be developed is "No."

For the issue of use, we have put "Limited," but only because of one study. Indeed, only one of all of HHS' planned studies can produce information on PPS' posthospital effects.

Unfortunately, that one focuses on hospitals providing posthospital care and does not look at effects on patients. Now, HHS' studies will produce information of a descriptive, noncomparative nature—as you can see from the chart—and will also show changes over time for some posthospital outcomes. That is, use and expenditure. In addition, some highly limited data on patient condition at hospital discharge and on access and on quality may eventually be produced.

But while these studies may provide helpful information on whether use and expenditures have changed, they will not be able to say that any changes they find are due to PPS.

Further, the work being done by HHS on posthospital patient condition, access, and quality is only now starting up and will not provide even descriptive information until appropriate measures are identified and tested.

So in summary, Mr. Chairman, I think it is clear that HHS has little basis now for saying whether PPS does or does not affect posthospital care, and the work underway is so limited that it is unlikely to yield that information in the near future.

Finally, the gaps we found in HHS' evaluation raises a somewhat more general issue having to do with agency accountability for the effects of its policies. PPS represents a major policy shift in one of the biggest of all nondefense Federal programs, and it was widely anticipated that there could be large-scale ramifications for patients in the posthospital system.

Now, judgments can differ as to how the Department should have allocated its different resources to investigate the various effects of PPS on hospital versus posthospital services, on beneficiaries versus providers. But by putting so little effort into the evaluation of PPS effects on the posthospital care of patients, the Department leaves the impression that it attaches a very low priority indeed to these issues of critical importance to millions of Americans.

Thank you very much, Mr. Chairman. That concludes my statement. I would be happy to answer any questions you or other members of the committee may have.

[The prepared statement of Ms. Chelimsky follows:]

Prepared Statement of Eleanor Chelimsky

Mr. Chairman and members of the committee: It is a pleasure to be here today to report to you on the information that will be available to the Congress and the public about the effects of implementing a prospective payment system (PPS) for hospitals in the Medicare program on post-hospital care. I will be summarizing the preliminary findings of an ongoing GAO study, requested by this Committee, that examines current and planned HHS evaluations. Our work is still in progress and, as a result, the findings we will be presenting today should be regarded as tentative.

As you know, PPS was intended to control the rate of growth in Medicare expenditures for hospital care. This was to be accomplished by providing hospitals with strong incentives to contain their costs by carefully controlling the amount of services provided or limiting patients' length of stay or both. Shorter lengths of stay may mean that some patients are discharged at an earlier stage in their recuperation. As a result, reducing hospital lengths of stay could lead to increased use (and therefore costs) of skilled nursing facility (SNF) and home health agency (HHA) services. So, from the beginning, PPS contained within it the potential for saving hospital costs while increasing the use and cost of post-hospital services.

The Health Care Financing Administration (HCFA), which administers the Medicare program, has the primary responsibility for implementing PPS and for conducting research and evaluations related to PPS. Under the provisins of the PPS legislation, HCFA is responsible for submitting a series of annual reports to the Congress presenting the effects of PPS on hospitals, beneficiaries, and other health care providers, including SNFs and HHAs. While other entities, including the Prospective Payment Assessment Commission and the Utilization and Quality Control Peer Review Organizations, also have responsibilities for monitoring and evaluating PPS, the primary responsibility for evaluating PPS resides with HCFA.

In July 1984, this Committee asked GAO to perform four tasks:

Identify the range of issues regarding the likely impact of PPS on Medicare skilled nursing facility and home health care services, as well as on other long-term care services;

Develop criteria to determine which of these issues are most important for federal evaluation efforts and apply these criteria to the range of issues to select a set of priority concerns;

Determine what data and information are and are not available to address these priority concerns and propose an evaluation plan to be used with specific data adequate to monitor and analyze these issues; and

Compare these plan specifications with the evaluation plan and data collection HHS intends to carry out, in order to determine how well HHS's evaluation efforts will answer the priority concerns.

We provided you with an interim report last February that focused on our findings from the first two tasks (GAO/PEMD-85-8, dated February 21, 1985). From our review of available information and interviews with individuals having firsthand experience with PPS, we identified and presented what we found to be the four key issues related to the post-hospital care of Medicare patients. These issues are:

Have patients' post-hospital care needs changed?

How are patients' needs being met?

Are patients having access problems?

How have long-term care costs been affected?

Today we will present our preliminary findings from the whole study, focusing especially on the last two tasks and the information that the Congress can expect to receive from HHS on all four key issues. Our work complements the report recently released to this committee by the Office of Technology Assessment (OTA) that examined approaches for evaluating the effects of PPS on a wide range of outcomes. The OTA report focused primarily on hospital issues such as quality of care and medical technology. We will concentrate on the extent to which it is feasible to address issues related to post-hospital care, given the complexities of the health services environment, the manner in which PPS was introduced, and the availability of appropriate measures and data. We will also review the work being done in this area by HHS. Very briefly, our finding is that some studies prividing information on the effects of PPS on post-hospital care can be done but that HHS is doing relatively little to develop this information.

WHAT CAN BE DONE?

We have translated the four key issues developed in our letter report into evaluation questions about the effects of PPS on five general outcomes. These outcomes are:

1. Patients' condition at hospital discharge,
2. The use of post-hospital services,
3. Expenditures for those services,
4. Access to those services, and
5. Quality of care delivered by post-hospital services.

Three types of information about these outcomes could be generated. Descriptive information addresses the general question of "what is happening now." This type of information is useful for characterizing the status of post-hospital services and patients under PPS and for identifying current problem areas. Descriptive information is usually relatively easy to collect, if appropriate measures are available. However, it does not provide any indication of whether the situation is different now from what it was before PPS. As a result, descriptive studies alone cannot give us information about the effects of PPS, because they do not contrast information from before and after the system's implementation.

Change-over-time information addresses the question of "how what is happening now is different from what was happening before PPS." Studies designed to develop this type of information can detect developing trends or problems and estimate their magnitude. However, data from periods before a policy change like PPS are often more difficult and costly to obtain than is after-the-fact descriptive information, especially when the change has been made without any provision for collecting baseline data. Moreover, it is often impossible to separate the effects of other factors from those caused by PPS. Thus, while change-over-time information can show whether a change occurred, it is generally a weak guide on which to base policy because it cannot show *why* a change occurred.

Attributive information is needed if we observe changes in post-hospital outcomes and want to address the question of "what caused them—PPS or something else." In addition to indicating specific factors that are responsible for the changes observed, this type of information also provides descriptive and change-over-time information. Decisionmakers who must have a strong understanding of the effects of PPS on, say, the quality of post-hospital care should be receiving attributive information. In our opinion, attributive studies are needed to guide policy choices and to avoid either improperly blaming PPS for problems it did not cause or crediting it with improvements for which it was not responsible.

ARE ATTRIBUTIVE STUDIES OF PPS POSSIBLE?

In a word, "yes." In two words, "yes, but." Our forthcoming report will include the detailed technical analyses that led us to this conclusion. Today, I will summarize our findings rather than present the detailed technical analyses.

In general, we believe adequate evaluations of the effects of PPS on post-hospital care can be done but they will be complex and difficult. They will require nationally representative samples in order to avoid potentially misleading results based on samples that do not appropriately capture the important variations among providers. They will require some means of ruling out factors such as the influence of the Tax Equity and Fiscal Responsibility Act of 1982 and the preexisting trend of expanding home health care that could account for observed changes. They will have to rely on data that are already recorded because all hospitals not excluded from PPS and all patients within those hospitals have been affected by PPS. Because evaluations of the effects of PPS must rely on existing data, any measures of the outcomes of interest that are developed for this purpose will have to be tailored for use with these data. In addition to resolving these problems, the studies will also have to be sensitive enough to detect what may initially be small changes that could, nonetheless, be important, either intrinsically or as they grow over time.

Of the five general outcome areas we identified earlier, two—use and expenditures—will be relatively easy to evaluate. The remaining three—patient condition, access, and quality of care—will be more difficult.

OBTAINING ATTRIBUTIVE INFORMATION ABOUT USE AND EXPENDITURES

If we refer now to Exhibit 1, we can see that data from the Medicare Statistical System—that is, billing data—could yield important information about the effects of PPS on Medicare use and expenditures for SNF and home health services. In addition, readmissions and mortality could be used as global indicators of the quality of care. The Medicare Statistical System does not include any data useful for assessing the effects of PPS on the remaining outcomes.

We believe that one approach, technically known as the interrupted time series design, is especially appropriate in this situation. This approach would use several years of pre-PPS and post-PPS Medicare data to develop estimates of the difference between what occurred after the implementation of PPS and what would have happened in the absence of PPS. Several statistical techniques are available for developing these estimates. A particular merit of this approach is that the use of a long series of pre-PPS observations can help evaluators to rule out a variety of alternative explanations for any observed change occurring at or after the implementation of PPS. For example, this approach could allow evaluators to separate the effects of PPS on the use of home health services from the general increase in use that was occurring before PPS.

Developing the necessary time series from the Medicare Statistical System would require extensive reorganization of the Medicare data. Currently, the structure of the Medicare data on use and expenditures (i.e., the Utilization Record) is based on individual patients' bills in the order in which they are processed by HCFA. In order to be used for evaluation studies, the data would have to be reorganized into a structure based on the services individual patients receive during an episode of illness associated with a hospital stay. They would also have to be sorted chronologically by date of hospital discharge. A project that HCFA has started, called the Medicare Automated Data Retrieval System, represents one approach toward accomplishing the necessary reorganization.

The costs and time involved in reorganizing Medicare data and doing the necessary statistical analyses are likely to be relatively small compared to the costs associated with collecting new data. Given its importance and the relatively low cost, we see no reason why this type of work should not be done now.

OBTAINING ATTRIBUTIVE INFORMATION ABOUT PATIENTS' CONDITION AT DISCHARGE AND ABOUT ACCESS TO AND QUALITY OF POST-HOSPITAL CARE

One approach to developing attributive information about the remaining outcomes would help get around the problem of the lack of data on these outcomes in the Medicare Statistical System. This approach, based on data from medical or other records maintained by providers, involves comparing changes in outcomes for Medicare patients discharged from hospitals under PPS with those for patients discharged from hospitals coming under PPS at a later time. This comparison is possible because hospitals began operating under PPS at different times, depending on the starting dates of their Medicare cost-reporting years. The starting dates are spread throughout the year, although they are concentrated at the beginning of January, July, and October. Assuming that the groups of hospitals are generally similar, differences in outcomes could reasonably be attributed to PPS. For example, if patients discharged from hospitals under PPS were generally in less stable condition than patients discharged from hospitals not yet under PPS, as well as less stable than patients discharged from the same hospitals before PPS, then there is reason to believe that PPS caused this difference.

As Exhibit 2 illustrates, this approach could produce information on the effects of PPS on patients' condition at the time of hospital discharge and better information about effects on the quality of post-hospital subacute care than can be obtained from Medicare data on readmission and mortality alone. It may also be possible to generate some information on the use of post-hospital care by patients needing such care—that is, on access to needed care. We believe it would be possible to develop a measure such as this.

Studies using medical or other records maintained by providers are likely to be more costly and time-consuming than studies using the Medicare data because of the need for extensive data collection and for additional work on developing valid and reliable measures that can be used with medical records. The potential benefits of these studies, however, are not limited to producing information on how PPS has affected Medicare patients and post-hospital health care providers. They could also provide measurement instruments for, and experience with, conducting evaluations of post-hospital care based on medical and other records maintained by providers.

Given the amount of mandated work that HCFA has to do already and the limited funds and staff available for that work, the cost and time required to develop the necessary measures and conduct these studies should be considered. Therefore, in discussing an overall plan for evaluating the effects of PPS, we emphasize the importance of using the results of attributive studies based on Medicare data to direct further studies and of prioritizing the entire range of information needs before devoting substantial resources to studies requiring extensive data collection. For example, if the results of analyses of Medicare data indicate that PPS has caused increased hospital readmissions, studies focusing on patient condition at discharge and placement in appropriate post-hospital settings would be important. As we have indicated, this would require work on the development on valid and reliable measures.

WHAT IS BEING DONE BY HHS?

Exhibit 3 lists the major sources of information that HHS will have available over the next few years for addressing questions about PPS. It includes some basic activities; relevant past studies, particularly large surveys of medical expenditures; current studies targeted at developing change-over-time information; and planned work.

According to congressional mandate, HHS is supposed to provide the Congress with information on the effects of PPS primarily by way of annual reports due at the end of each calendar year. The first report was due in December 1984 and has not yet been delivered. Our review of HHS's work on the annual reports indicates that no attributive information on post-hospital care will be included in any of the currently planned reports, although HHS has plans to include some change-over-time information on post-hospital care in the reports for fiscal years 1985 and 1986.

While HHS is studying the feasibility of developing better information on the effects of PPS on post-hospital care, it is doing very little work on studies that could produce attributive information on the issues of concern here. The work that is under way for developing descriptive and change-over-time information related to post-hospital care issues is also limited. In general, these studies will provide information addressing a broad range of health care issues rather than focusing specifically on PPS and post-hospital care.

In addition, I would like to draw your attention to the study costs shown in Exhibit 3. While many of these studies are primarily descriptive surveys (e.g., the Long-term Care Survey and the National Nursing Home Survey) rather than attributive studies, the point is that the cost of any major effort to collect primary data is likely to be relatively high. Therefore, we believe that the costs of the attributive studies that we have identified should not be too quickly rejected because of their projected price tags but rather should be considered in the context of the high costs that are usually involved in obtaining primary data.

Exhibit 4 summarizes our findings on the types of information that HHS will produce on the five outcomes I presented earlier.

In terms of patients' condition at hospital discharge to post-hospital care, we found that no attributive and only limited descriptive and change-over-time information will be produced. One relevant study is a pilot test that uses medical records to examine changes in patient condition from before PPS to after PPS for two medical conditions in a small sample of hospitals in southern California. A contract to extend the work to more conditions and hospitals is being negotiated although the details of the study are not yet available. A second study will provide information on changes in the types of patients entering skilled nursing facilities and home health agencies and changes in their care needs.

Analyses HHS has planned will not provide attributive information but should provide adequate change-over-time information on the use of and expenditures for SNF and HHA services. In addition, HHS plans to do similar analyses of readmissions and mortality. It is not clear whether these analyses will separately address outcomes for patients who use and for patients who did not use post-hospital services. However, this is the only information on the quality of post-hospital care that is likely to be produced.

We did not find any work ging on at HHS that directly addresses the issue of access to post-hospital care for discharged Medicare patients, other than the work being done as part of the feasibility study mentioned earlier. Work in this area is seriously hampered by the lack of suitable measures of access. HHS has planned some work that will review available data for changes in bed supply or service use. These measures are sometimes used as proxies for measures of access.

Work currently in progress at HHS could lead to better measures of patients' condition and quality of care and provide a basis for future studies in these areas. This work as well as efforts to develop measures of access to post-hospital care will have to be done before any type of information can be produced on these outcomes.

Overall, as we show in Exibit 4, we found that HHS is doing very little to develop information that would enable either HHS or the Congress to determine whether PPS caused any observed changes in post-hospital subacute services. We found only one such study, the first listed under attributive studies in Exhibit 3, that has as one of its primary objectives the development of attributive information. The investigators hope to provide information on the effects of PPS on the provision of post-hospital care by hospitals through examining changes in the number of hospitals offering post-hospital services and in the volume of patients treated, while controlling for other economic and social factors. However, this study will address only one provider-oriented, and no patient-oriented, aspects of post-hospital care. Further, it is not scheduled for publication until 1987.

CONCLUSIONS

With regard to what can be done, we believe that evaluations of some of the effects of PPS on post-hospital outcomes are feasible. We have identified two possible approaches to producing attributive information. One, interrupted time series analysis of Medicare data on use, expenditures, readmissions, and mortality, is likely to be relatively inexpensive and could be conducted in a timely fashion. The results of studies of this type could help target further efforts to develop a more complete understanding of the effects of PPS. Completion of the Medicare Automated Data Retrieval System would help facilitate this approach. The second approach would be based on data in medical and other records maintained by providers. Studies of this type will require the development of measures and, like all extensive data collection efforts, are likely to be relatively expensive and take time to complete.

With regard to what HHS is doing, we did not find evidence of intentions to do the types of attributive studies we have just identified. We have found, however, that it will produce descriptive and change-over-time information on Medicare use and expenditures for post-hospital services. HHS will also provide some limited descriptive and change-over-time information on patients' condition at hospital discharge and on access and quality. We found only one study under way that is specifically targeted to developing attributive information on post-hospital care outcomes. Finally, the work under way on outcome measures and on methods of medical record abstraction could prove useful not only for future attributive studies but also for health service research in general.

In short, we have found that HHS has not done, and currently does not plan to do, much work to produce attributive information on changes in patients' condition at hospital discharge or in the use of, expenditures for, access to, and quality of post-hospital care. The one attributive study planned is focused on providers, not patients. At present, HHS has no adequate basis for concluding that PPS does or does not affect post-hospital care; work under way is limited and unlikely to yield information that would support such conclusions in the near future.

This concludes my prepared statement. I will be happy to answer any questions you or other members of the Committee have.

Chairman HEINZ. Thank you very much, Ms. Chelimsky.

A very brief summation of your statement is that an evaluation of access to care and the quality of care is feasible for the Department of Health and Human Services and HCFA to achieve—but they are not achieving it.

Is that a fair statement?

Ms. CHELIMSKY. Yes, it is a fair statement. It is also true that I do not think the effects information is being achieved on any of the five variables, really. There will be change-over-time information which cannot attribute to PPS what has happened—in other words, something else might have caused it—which gives policymakers problems for addressing the issue. If you do not know that it is PPS that caused something, changing PPS may not help it, since the problem may be the aging of the population or some other problem.

Chairman HEINZ. And yet the administration has, on paper, in testimony, and in the press, held out a variety of kinds of data which they say are proof that the Medicare Program is running smoothly, that there are no substantial problems with quality of care.

How is it possible, in your judgment, for them to do so? Is there any validity to the administration's claims that they have reason to believe that there are no problems with quality of care or with access?

Ms. CHELIMSKY. Well, first of all, the issue of quality of care and access that we have looked at refers only to the posthospital component. We have not looked at inpatient hospital care. That is really not the issue that we have looked at at all——

Chairman HEINZ. I understand that, but you had to look, as you pointed out at the beginning, at the condition of the patients up on discharge from the hospital.

Ms. CHELIMSKY. Yes, yes. We do believe that they do not have any evidence that would support making any conclusion at all about any of these five issues, whether there are problems or there are not problems.

I would say that they have not looked for the evidence, not that there is not any.

Chairman HEINZ. Could you elaborate on the reasons why it is so important to obtain the information about the extent to which PPS has caused changes in patient condition, quality of care, and so forth. Isn't it enough, as the agency maintains, to know that things have changed—that things are worse now than before PPS came into effect?

Ms. CHELIMSKY. Well, first of all, it is not clear to me that on the five issues that we have called extremely important issues that they are going to have change-over-time information. There may be some, but it is not clear at all from those charts that they are going to have it on anything other than use and expenditure.

Second, I think it is terribly important to know whether PPS has caused any problems that we have seen, as I have just mentioned, because if the problem is that there is an apparent effect which is caused by a change in technology, for instance, which has nothing to do with PPS, then we won't help matters by tinkering with PPS. You see, so many things have occurred at once in the program that it is extremely important to partial out what is due to PPS and what might be due to something else. If there is nothing that one can do from a policy point of view about the aging of the population, for example, then one should not try to do something. On the other hand, if we know that it is PPS that has caused these problems, if people are being let out sooner and if they are not having access to appropriate care, then it is a matter of changing the PPS legislation.

Chairman HEINZ. So what you are saying is that since there is a lot going on out there, if appropriate studies are not done, and if appropriate data are not analyzed, it will be impossible to determine causality?

Ms. CHELIMSKY. Exactly.

Chairman HEINZ. And without being able to pin down causality, we cannot make intelligent policy changes.

Ms. CHELIMSKY. The most intelligent ones. I am sure they will always be intelligent.

Chairman HEINZ. They just may not work.

Ms. CHELIMSKY. Right. Another issue. [Laughter.]

Chairman HEINZ. One thought crossed my mind as I looked at all of your charts. It seems as if the administration might be symbolized by one of those little carvings you used to see brought back from the Orient, of three monkeys or lemurs or chimpanzees, one with hands over its eyes, the other with hands over its ears, and the last with hands over its mouth—so that they did not see or hear or speak any evil.

Is that a valid analogy here?

Ms. CHELIMSKY. Well, I am not sure about the monkeys. I do feel, however, that——

Chairman HEINZ. This is not a racial slur on monkeys.

Ms. CHELIMSKY. Yes. But the thing I do feel is that what you see from these charts does translate into a very low priority for the issue of posthospital care. I mean, I think it is really very hard when you look at our exhibit 3 not to recognize that very little is going into posthospital care, and nobody is really looking at it over there, and I do not really understand why that is. I cannot explain to you why that is, but it is not happening. Most of the other studies are looking at other things, as well as not looking at effects, but rather at descriptive issues and change-over-time issues.

I also should mention that this is a very difficult and complex area. What we are talking about here is the development of measures that people have been trying to do for some time and our feeling is that enough progress is being made that we can do more now.

Chairman HEINZ. You have not said much about the potential of using the PRO's, the peer review organizations, to collect data about the impact of prospective payment, particularly on quality of care. Do PRO's currently collect data that are useful to assess the quality of care?

Ms. CHELIMSKY. Well, our issue again, of course, is posthospital care, and they have not been involved too much in posthospital care. The other thing that makes us wonder a little bit about PRO's is that, of course, there are 54 of them, and like all peer review organizations, each one develops its own standards. So that, while I feel that they are terribly useful at a local level, I am not sure about the national data that we could get, given that all the standards are different.

Another thing is that, I think, they have been mostly used for utilization as opposed to quality of care sorts of issues. So I do not know what that would give us, and so we have not really harped on that as a possible solution.

Chairman HEINZ. Let me ask you what is both a personal and subjective question. Are either of your parents alive?

Ms. CHELIMSKY. No.

Chairman HEINZ. No. Were they alive today, would you have any reservations about their going as a Medicare beneficiary with a fairly complicated serious illness to a hospital? Would you have greater reservations today under the prospective payment system than you might have had 5 years ago prior to the change?

Ms. CHELIMSKY. Speaking personally as a citizen, yes, yes, yes, very much so. I would have great concern.

Chairman HEINZ. Now, if you had to sum that up in a sentence or two, what would it be, speaking as a citizen?

Ms. CHELIMSKY. My own personal feeling would be that I would be very concerned to know very well the doctor that my parents were using, to be sure that, given the kinds of incentives that there are today, the kinds that you described earlier in your statement, I could be absolutely certain that the issue of his or her health would be paramount and that there would not a kind of cavalier attitude toward moving people out early.

Chairman HEINZ. Thank you for answering that question. I recognize you are really not answering it as an expert from GAO, but as a citizen, with an unusual citizen's expertise, admittedly, but a citizen nonetheless.

Ms. CHELIMSKY. Yes

Chairman HEINZ. Let me ask you one last question before I yield to Senator Chiles. When do you expect to have the final GAO Report ready?

Ms. CHELIMSKY. Well, at the present time, it looks like January. We are scrubbing it down now. We are trying very hard to get all the cost figures right for the two studies that we are recommending, and it is really quite difficult, looking at all the options and costing them out to make sure that we are quite right. So I think January, at this point.

Chairman HEINZ. Very well. Thank you, Ms. Chelimsky.

[Subsequent to the hearing the following was received from Ms. Chelimsky for the record:]

UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

PROGRAM EVALUATION
AND
METHODOLOGY DIVISION

[illegible]

The Honorable John Heinz
Chairman, Special Committee on Aging
United States Senate

Dear Mr. Chairman:

Thank you very much for your kind comments on my testimony. I am glad to hear it was useful and greatly relieved that you found it clear! Sometimes, it is quite difficult to be as limpid as one would like when the issues are highly technical, as they are in the evaluation of PPS.

Before commenting on the specific studies that Mr. Haddow has described in his testimony, I would like to raise three general concerns.

First, Mr. Haddow stated in his oral testimony that the decision to focus HCFA's monitoring and evaluation efforts on issues of hospital behavior and inpatient care was an allocative decision. This implies that, given limited resources, a decision had to be made about which evaluations were most important, and the HCFA decision was to focus evaluation efforts on the direct target of the PPS reform, that is, hospitals.

Our study indicates that data are available at HCFA which could be used to address the effects of PPS on the use of and expenditures for SNF and home health services (as well as readmissions and mortality) in a timely and relatively inexpensive manner. Therefore, while we agree with the premise that allocative decisions need to be made about how to use HCFA's resources efficiently, it is our opinion that limited resources do not explain the paucity of effort on evaluations of the effect of PPS on the post-hospital outcomes mentioned above.

Second, Mr. Haddow strongly defended HCFA's reliance on the work of the PROs in monitoring the quality of inpatient care. He also said that arguments presented by the PROs regarding expansion of their role in reviewing quality of care should be discounted because they are self-serving. But it is our opinion that reviewing readmissions, which is the primary mechanism the PROs use for insuring the quality of inpatient care to Medicare beneficiaries, is fundamentally flawed with regard to its usefulness for monitoring quality of care at the *national level in two respects. First, as you know, the* limitations on the definition of a readmission and the type of review required mean that many aspects of the care given during the hospital stay are not systematically examined. For example, rates of surgical complications or iatrogenic disease are not routinely monitored. The second respect in which the current approach of reviewing only readmissions is flawed is that it fails to deal effectively with the appropriateness of hospital discharge decisions. Under the current system, for example, a patient who was prematurely discharged and died without returning to the hospital would not be identified. Similarly, while PROs review whether readmissions (within a set time) were the result of premature discharge, they do not examine the possibility that a patient needed but could not or did not obtain appropriate post-hospital care. It is our opinion that a hospital discharge decision cannot be judged appropriate without knowledge of these factors. For example, discharging a patient without post-hospital care may be appropriate when there is a spouse capable of providing assistance; the same discharge might be inappropriate if the person lived alone.

Having stated this opinion about the overall adequacy of the PRO monitoring of readmissions, let me also recognize that the wider scope of review suggested by my comments would require the development of an approach to assessing the need for post-hospital care before it could be recommended for wide spread implementation. As you know, we testified that validated measures have not yet been developed for determining patient health status at discharge. Without such measures and without an understanding of post-hospital care needs, evaluations of the effects of PPS on inpatient as well as post-hospital care will be inadequate.

Third, Mr. Haddow has indicated that approaches for monitoring and/or evaluating the effects of PPS on post-hospital care (including on the quality of that care) will be developed in conjunction with the expansion of payment reforms--that is PPS-- into home health and nursing home care. But waiting until new forms of prospective payment are introduced before developing baseline data on measures of post-hospital care would reproduce precisely the same sorts of problems that have hindered efforts to monitor and evaluate the effects of the hospital prospective payment reform. This approach ignores the lessons of the past two years and would, once again, seriously limit the available options for conducting useful evaluations of the effects of payment reforms on the full range of Medicare-covered services. Given this experience with evaluating the effects of PPS, we believe that a decision to reproduce the same kind of uncertainty about the effects of a new shift in policy is inexplicable.

With regard to the annual report, we have read the sections which deal with post-hospital care (our area of expertise) and offer two observations. First, in reading the sections on readmissions, mortality, and discharge rates to post-hospital settings, we were struck by the lack of attention paid to the role of post-hospital care in plans for analyzing the impacts of PPS. For example, on page 7-41, the following statement is made: "Changes in the discharge rate to skilled nursing facilities (SNF's), intermediate care facilities (ICF's), and home health care will also be analyzed. These data are only available beginning with the implementation of the PPS in October of 1983; they thus cannot be compared to pre-PPS patterns." While it is true to say that hospitals were not required to provide discharge destinations prior to PPS, it is not true that information on where patients went after the hospital is unavailable. By combining billing records for hospitals with those for SNF's and home health care, the discharge rates to these facilities could be obtained. HCFA has done this type of file merging in the past, and could do it now. Discharges to ICF's cannot be determined for pre-PPS periods. Finally, we feel it is appropriate to point out again that the validity and reliability of the discharge destination reported on hospital abstracts has been seriously questioned.

Second, the information presented in the annual report on discharges to SNF's, ICF,s and home health is based on hospital discharge abstract information and is suspect on that ground. However, there is an interesting pattern that emerges if one compares PPS bills with nonPPS bills across the three types of care. While the total percentages going to any one place are small (less than 5 percent) for PPS bills, they are 2.9 to 3.6 times higher than the percentages for non-PPS bills. In light of this apparently large difference in the use of post-hospital services, it is unfortunate that the annual report contains no analyses of SNF and home health bills. In addition, we found no mention in the annual report of plans for such analyses.

With regard to your formal questions concerning the five studies mentioned by C. McClain Haddow in his testimony before the committee on November 12, 1985, two general points should be made. First, our work did not include an extensive review of the work that the Department is doing to examine the quality of inpatient care or access to that care. As a result, we cannot appropriately comment on whether these studies will provide attributive information on the effects of PPS on access to inpatient care or the quality of that care. We did, however, examine the available documentation on each of the five studies cited with respect to information that would be generated relative to post-hospital care. We have attached, for your information, short write-ups of each study that were provided to us by HCFA in the course of our work (see Attachments 1 to 5).

Second, we would like to reiterate our conclusion, presented in testimony, that HHS currently has no work in progress or planned in the near future which will provide attributive information on the quality of post-hospital care or on beneficiaries' access to that care. Therefore, the specific comments we make below should be interpreted as elaboration of this basic point.

Study 1: "One of these studies, being conducted by our Office of Research and Demonstrations, is to detect broad PPS related effects on quality of care by examining the outcomes of hospital care on the health status of patients (C. McClain Haddow, Testimony, November 12, 1985)."

Description:

As indicated in Attachment 1, the analyses in this study are designed to measure changes in hospitalization as a result of PPS that may impact on Medicare beneficiaries. The analyses will be based on hospital data from the Medicare system.

Information on post-hospital care

This study will examine a variety of quality outcomes including readmissions, mortality and transfers to other hospitals. It will not provide any information on quality of care in post-hospital settings or on access to post-hospital services.

Limitations

In Attachment 1, HCFA explicitly recognizes the difficulties of making causal inferences on the basis of this study (i.e., "...the lack of control groups to account for exogenous influences"). While the Medicare data could support attributive studies, the current design of this study only permits an examination of changes from before PPS to after PPS. In addition to the lack of attributive information, we also would like to point out that these outcomes are limited indicators of health status and/or quality of care. While changes in these outcomes may be indicative of changes in quality of care, there are also a number of other explanations that have nothing to do with quality of care.

Study 2: "A study by the Commission on Professional and Hospital Activities to measure the general effects of PPS on the quality of inpatient hospital care ... (C. McClain Haddow, Testimony, November 12, 1985)."

Description

This study is described by HCFA in Attachment 2. It will examine changes in "quality-related" processes and hospital utilization activities by comparing pre-PPS data to post-PPS data. This examination is to be based primarily on data from the Professional Activity Study maintained by the Commission on Professional and Hospital Activity (CPHA), supplemented by data from several sources maintained by CPHA.

Information on Post-hospital care

This study will be based exclusively on hospital data and will not address either the quality of or access to post-hospital care.

Limitations

As recognized by HCFA, the sample of hospitals participating in the Professional Activity Study is not representative of all hospitals participating in the Medicare program. For example, investor-owned and government hospitals are very underrepresented in the database although they account for 31 percent of Medicare bills under PPS.

Study 3: "A study [by the Rand Corporation] to evaluate the impact of PPS on the quality of care by assessing potential effects on changes in inpatient hospital treatment patterns through a thorough examination of the medical record, and resultant health status outcomes (C. McClain Haddow, Testimony, November 12, 1985)."

Description

This study is described in Attachment 3. This study will examine medical records for separate samples of patients discharged from hospital prior to and after the hospitals came under PPS. It will develop abstraction forms tailored to a limited set of medical conditions and apply them in a sample of hospitals. As the attachment indicates, the exact design and scope of this study are still under negotiation.

Information on post-hospital care

The study, as it is presently designed, will not obtain any information on the quality of or access to post-hospital care.

Limitations

The study will collect extensive data on the treatment provided to hospitalized Medicare beneficiaries with a small, carefully-selected set of medical conditions. The plan is that those conditions will represent the range of possible changes in inpatient medical practice caused by PPS. However, the results will not necessarily be generalizable to other conditions. In addition, the study is not designed in such a way that valid attributive information is likely to be obtained.

Study 4: "A study to investigate the feasibility of using Medicare (non-intrusive outcome) administrative data to detect quality of care levels within individual hospitals (C. McClain Haddow, Testimony, November 12, 1985)."

Description

This study is described in Attachment 4. Its primary purpose is to develop measures based on data Medicare routinely collects (both Part A and Part B data) that could be used to monitor the quality of hospital care from within HCFA. It should not be considered an evaluation of quality of care. It could, however, provide a useful basis for future evaluations based on Medicare data.

Information on post-hospital care

This study will not produce any information on the quality of or access to post-hospital care.

Limitations

The primary potential limitation of this study is its dependence on the validation of quality indicators using medical record data. It is not clear the extent to which suspected quality problems identified using administrative data can be validated by examination of medical records without also having direct contact with the patient and providers.

Study 5; "A study by the Urban Institute to evaluate PPS quality impacts on ESRD Medicare beneficiaries, a subset of the Medicare population generally assumed to represent an unusually high medical risk group (C. McClain Haddow, Testimony, November 12, 1985)."

Description

This study is described in Attachment 5. This is a study of changes in the use and cost of services provided to ESRD patients under Medicare. It does not, as far as we can determine, have any specific quality of care component.

Information on post-hospital care

The study will not provide any information on post-hospital care.

Limitations

While the ESRD population is easily identified and "vulnerable", it also is likely to be particularly unrepresentative of the remaining Medicare beneficiaries.

With kind regards,

Sincerely yours,

Eleanor Chelimsky
Director

Attachment 1

HCFA SUPPORTED QUALITY IMPACT STUDIES

ABSTRACT

STUDY NAME:

Beneficiary
Impact Study

PRINCIPAL INVESTIGATOR:

Intramural, HCFA, OR
Study: Eggers, Lubitz,
Bebee, and Riley

PROJECT DATES:

Begin: March, 1984
End: Ongoing

Results available in
September of each year.

STUDY COSTS:

In-house study

Data collected as
part of on-going
Program operations.

PURPOSE:

This annual study is intended to reveal broad statistical trends and regional variations in hospital utilization, patient outcomes, use of non-hospital Medicare services, and DRG concentrations within and among hospitals.

DATA BASES:

In-house Medicare data bases will be use for this study including: the 1981 (pre-PPS) "MEDPAR" file, the 1984 (post-PPS) Part A "Inpatient Hospital Records" (PATBILL) File, the Admission Pattern Monitoring System, and the Medicare Enrollment File.

METHODS:

Within this broad pre/post PPS descriptive and multivariate statistical study specific hypotheses related to PPS impact on quality of care will be formulated. These hypotheses include the following possible PPS-induced changes: 1) Increases in re-hospitalizations, 2) increases in hospital and post hospitalization mortality rates, 3) decreases in the ratio of ancillary/total charges, 4) decreases in overall length of stay, 5) decreases in the average age of Medicare patients, and others. In addition, specific DRG's may be studied, in depth, by assessing changes in patterns of care as reflected in charge patterns, appearing on the bill.

UTILITY/LIMITATIONS:

This project's major advantage and potential utility lies in the fact that it draws upon existing data systems, and, thus, provides an efficient, low cost approach for studying quality impacts across the entire Medicare population. Limitations involve possible changes in hospital financial data reporting practices in the periods being studied, and the lack of control groups to account for exogenous influences. Statistical evidence produced from this study will not be confirmed by followup field work.

Attachment 2

HCFA SUPPORTED QUALITY IMPACT STUDIES

ABSTRACT

STUDY NAME:

Commission on Professional and Hospital Activities (CPHA) Study

PRINCIPAL INVESTIGATOR:

Michael J. Long
Susan I. DesHarais

PROJECT DATES:

Begin: October, 1984
End: September, 1988

STUDY COSTS:

$145 K

PURPOSE:

This study will measure selected quality-related process and hospital utlization activities comparing pre and post PPS periods.

DATA BASES:

Data for this project will be obtained from CPHA files including: The Professional Activity Study (PAS), the Medical Administrative Profile (MAP), the Quality Assurance Monitor (QAM), and MEDCOST.

METHODS:

Twenty-four hypotheses (related primarily to process) will be tested utilizing the information resident on CPHA files. Examples of hypotheses involve the following PPS-induced patterns for Medicare patients: 1) Reductions in ICU days, 2) reductions in pre-operative lengths of stay, 3) increases in the percentage of patients discharged to SNF's or HHA's, 4) increases in the percentage of cases where normal tissue is removed at time of surgery, and 5) reductions in the number of units of blood administered. The time for this study includes 3 years preceding PPS (81-83) and 4 years after PPS (84-87). Data for the third quarter of each year will be analyzed.

UTILITY/LIMITATIONS:

This study utilizes existing data from a major abstract service and, thus, provides a relatively low cost approach for tracking quality of care in hospitals -- avoids costly ad hoc data collection. The data used for this project is more clincally detailed than information contained on the Medicare claims document, thus allowing for more detailed process analyses than studies relying on financial/administrative data. The study is somewhat constrained by the non-random participation of hospitals in the CPHA abstract service.

Attachment 3

HCFA SUPPORTED QUALITY IMPACT STUDIES

ABSTRACT

STUDY NAME:	PRINCIPAL INVESTIGATOR:
Rand Pilot Study	Katherine Kahn
PROJECT DATES:	STUDY COSTS:
Begin: Febuary, 1985 End: December, 1985	Under negotiation

PURPOSE:

The intent of this project is to test the effectiveness and costs of a clinically detailed methodology for assessing the impact of PPS on quality of care, as measured by process and outcome variables available from the medical record.

DATA BASES:

This study will utilize data from a sample of medical records for two disease conditions, selected from a cross-section of hospitals in Southern California. The sample size for this study will consist of a small number of medical records, representing patients discharged prior to and after the implementation of PPS.

METHODS:

The data collection methodology will consist of manually abstracting and relating complex process and outcome variables available from medical records. Examples of process related data include: numbers and types of diagnostic tests, levels and intensity of nursing services, use of special care units, and discharge status; types of outcome measures, for example would include: incidence of sepsis, readmissions to ICU's, etc. Each set of measures will be tailored to the disease condition being studied. This project will also involve methods of adjusting for disease severity and comorbidity in the application of process oriented treatment protocols. Detailed abstraction instruments, and guidelines will be developed , as part of this study. (The final scope and direction of this study are currently under discussion).

UTILITY/LIMITATIONS:

This project will provide information on the feasibility, costs and utility of an expanded (national) study, and may provide preliminary data on PPS impact in the Southern California area.

Attachment 4

HCFA SUPPORTED QUALITY IMPACT STUDIES

ABSTRACT

STUDY NAME:

Rand Investigation
Into Quality Indicators

PRINCIPAL INVESTIGATOR:

Kathleen Lohr
Mark Chassin

PROJECT DATES:

Begin: October, 1984
End: December, 1987

STUDY COSTS:

$861 K

PURPOSE:

This project is intended to isolate a set of "non-intrusive" indicators maintained in existing Medicare information systems, useful for monitoring quality of care under PPS.

DATA BASES:

The following HCFA files will serve as the primary data bases for this study. 1984 Part A "Inpatient Hospital Records", the "Provider of Service (POS)" Hospital File, the "Payment Record" File (Part B data), and a sampling of medical records from two states (California and Pennsylvania).

METHODS:

This study involves a variety of methodological approaches including: 1) a literature review to define "candidate" outcome measures, 2) statistical investigations into the (post-PPS) project data bases to identify suggestive "quality" patterns, 3) expert panel reviews of probable outcome measures, and 4) field validation of selected measures in two States. Field work will include abstracting data from a sample of medical records. These data will serve as a basis for confirming suspected quality problems, suggested by prior analysis of Medicare administrative data. Detailed abstract forms/guidelines will be developed prior to field work, along abstractor training sessions.

UTILITY/LIMITATIONS:

Selected/validated outcome measures could provide HCFA with an approach for identifying instances of sub-standard quality of of care, associated, for instance, with certain types of DRG's or hospitals. This approach represents a basis for formulating corrective action such as focusing PRO objectives and provider compliance strategies, and adjusting DRG pricing structures. The project may be constrained by insufficientally detailed process/outcome, quality related variables collected in Medicare administrative records.

Attachment 5

HCFA SUPPORTED QUALITY IMPACT STUDIES

ABSTRACT

STUDY NAME:

Learning from and Improving DRGs for ESRD Patients

PRINCIPAL INVESTIGATOR:

Philip J. Held
(Urban Institute)

PROJECT DATES:

Begin: September, 1984
End: August, 1986

STUDY COSTS:

$375,000

PURPOSE:

This study will assess the workings and impacts of the Prospective Payment System by Diagnosis Related Groups on the End-Stage Renal Disease portion of the Medicare population.

DATA BASES:

This study will use the Medicare Statistical System inpatient records to monitor the use of inpatient care for this population over time. The pre-PPS period will use the MEDPAR system of records while the post-PPS period will be based on the PATBILL records. In addition, the analysis will use the ESRD Medical Information System for detailed data on the ESRD beneficiaries such as cause of renal failure, type of dialysis therapy and transplant incidents.

METHODS:

The design is a straightforward pre-post examination of rates of use of services and per capita costs among ESRD beneficiaries. In particular the study will address the following issues: changes in the level of Medicare costs, changes in the type of hospitals to which ESRD patients are admitted, changes in the frequency and length of hospitalization, evidence of "DRG creep", changes in the components of inpatient costs, and evidence of cost shifts to other locations (e.g. outpatient settings).

UTILITY/LIMITATIONS:

This study's strength lies in the examination of a specific population for evidence of PPS impacts. The ESRD population is an easily defined and vulnerable population. In addition, they are a high cost population from the hospital point of view (ESRD patients will always require dialysis when hospitalized, a cost which is "hidden" in the overall DRG rate). As such there is the adverse incentive to avoid serving these beneficiaries. If such an incentive exists, it could show up in this population.

Senator Chiles?

STATEMENT OF SENATOR LAWTON CHILES

Senator CHILES. Thank you, Mr. Chairman.

I again want to congratulate you on holding these hearings, and your continued diligency in trying to followup on our prospective payment system and whether it is working and especially what kinds of hardships and problems it is causing our senior citizens, and trying to find out that information or not, and this continuation of your efforts in that regard.

Can you tell me, Ms. Chelimsky, has the Department followed the mandate of the Congress to provide the kind of information and do the kind of checking themselves to determine what kind of problems, if any, this is giving our senior citizens?

Ms. CHELIMSKY. Sir, we have looked essentially at the posthospital care component, and I cannot really speak to the others, although I think Dr. Bernstein probably can here. Jill, would you like to do that?

Senator CHILES. Well, we have been trying to get this information from them, I understand the chairman has now subpoenaed information from them. But you have had a chance to look, at the records, and you can tell us better than anyone whether they have complied with the Congress' mandate that they be checking on this and they provide this information.

Dr. BERNSTEIN. Well, as you know, the annual report which was due December 31 of last year has not yet been issued, and in that sense, they have not complied with a congressional mandate to produce that information.

The Department is working on a very large number of studies. Some have been delayed. Others are, I presume, proceeding on target.

The nature of the mandate to produce information on PPS impacts was fairly broad. The Department was asked to provide information on hospitals and other providers, as well as beneficiaries. Other providers is not spelled out——

Senator CHILES. Maybe I need to phrase this question in a different way. On a scale of 1 to 10, how would you say your review of the records and what they are doing—what kind of effort is being made on a scale of 1 to 10?

Dr. BERNSTEIN. On posthospital care issues, it would be a very low number, maybe a two. On the overall program, I do not think that we are ready to give an overall answer.

Senator CHILES. Thank you.

Chairman HEINZ. Ms. Chelimsky, we promised Mr. Haddow he could testify at 10 o'clock. There are a few more questions I have for you. Would it be possible for you to remain available for a little while longer today?

Ms. CHELIMSKY. Certainly, Mr. Chairman.

Chairman HEINZ. I thank you and your expert colleagues for your participation and your help.

Thank you very much.

Our next witness is C. McClain Haddow.

Mr. Haddow, I gather you have some prepared testimony. If you wish to summarize it in any respects, we will ensure that your complete testimony is placed in the record in full.

STATEMENT OF C. McCLAIN HADDOW, ACTING ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Mr. Haddow. Thank you, Mr. Chairman.

I am pleased to be here today to discuss an issue of the utmost importance, the impact of the prospective payment system on the quality of care provided to Medicare beneficiaries. I have submitted my complete statement for the record as well as responses to a number of pertinent questions posed by the committee, in an effort to provide the committee with a more complete view of how PPS actually impacts the quality of care for Medicare beneficiaries.

I would also respectfully request that the committee record be kept open for a reasonable period of time to allow for additional submissions from HCFA to further clarify some of the accounts presented by previous witnesses before this committee.[1] I believe this request is justified, Mr. Chairman, particularly in view of the puzzling array of actions recommended by the committee staff, including the subpoena issued late Friday afternoon for my appearance here this morning, long after I had communicated my sincere appreciation for the invitation to appear. My intent could not have been misunderstood by the committee staff.

In addition, in the few cases in which sufficient information was provided by direct testimony, or shared with HCFA by committee staff, our investigation has shown significant differences in the actual facts in the cases and the public testimony presented to the committee. We recognize that the judgments of individual members of this committee and subsequently, by the collective Congress, will depend upon the accuracy of the information provided to you.

HCFA will aggressively research each case history the committee staff has cited to support its findings and is willing to share with us in an effort to validate the efficacy as a basis for any change and refinement in public policy.

Chairman Heinz. Mr. Haddow, if I may just say so, it is all very well and good to research each and every case, but the committee is concerned with what is taking place out there. We have just heard from the General Accounting Office that you do not know what is going on out there, because you do not have the methodology or data to keep track. If we get into looking at this case or that case, and you spend all the energies, efforts and resources that you have—and yours are limited—you are never going to get to the bottom of the problem. You are going to hit the center of the doughnut and miss what is really important—that is having a statistically sound analysis and understanding of the effects of the prospective payment system on quality of care.

If we do not communicate on that point, we have got a serious problem.

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[1] No submissions were received from HCFA at time of printing.

Mr. HADDOW. Mr. Chairman, the committee has spent considerable time receiving testimony that we believe ought to be accurate, and we are willing to take the effort if the committee staff will provide to us the specific information to validate it, because it is upon that basis——

Chairman HEINZ. Mr. Haddow, you are totally missing the point.

Mr. HADDOW. Then the committee has missed the point, Mr. Chairman, because you spent considerable time looking at the anecdotal evidence.

Chairman HEINZ. Mr. Haddow, let me refresh your memory about some of your statements, and some of the people with whom you work.

You state, and I quote, "There is no data which indicates that the prospective payment system has adversely impacted the high quality of care that has been a tradition in our Nation's health community." That was you, on the 30th of September, before the House Budget Committee's task force on health.

On the MacNeil-Lehrer show a couple of days later, you and I had a little debate about this issue. You said, and I quote:

> For the first time in history, we are able to identify where there are problems of quality of care in the system, and we are now not only able to identify them, but through the implementation of sanctions against inappropriate providers of care, either the doctors or the hospitals, we are able to correct the problem, to prevent future abuses.

Now, look. The General Accounting Office has just been through your data system. Basically, they say you do not have one.

Mr. HADDOW. Mr. Chairman——

Chairman HEINZ. These statements, coming as they do on the heels of the testimony of the General Accounting Office, frankly show a lack of understanding of the problem—and I could think of a few other things to say about them. I think they are misleading. I think they are inaccurate. And I think what you are saying now diverts us from the issue, which is whether or not you are keeping track of things. Unless you can show us how you are keeping track, the answer is "No."

Mr. HADDOW. Mr. Chairman, I think that there is some confusion about the difference between posthospital surveys and inpatient surveys——

Chairman HEINZ. Of course, there is.

Mr. HADDOW [continuing]. And the GAO has not addressed the inpatient studies that we are doing. And the comments that you attributed to me, accurately, reflect our ability to track inpatient quality of care issues. We are doing a very good job at that. It is an allocative decision as to where we will apply resources.

Chairman HEINZ Just so the record is clear, the GAO did look at discharges of patients from hospitals; they had to——

Mr. HADDOW. They looked at posthospital stays, Mr. Chairman.

Chairman HEINZ. One of the most critical problems with the prospective payment system occurs at the point when people are discharged. While access to care is an important concern, the biggest single finding that we have from our investigation is that patients indeed are being discharged "sicker and quicker." I do not know of anybody who disagrees with that particular observation——

Mr. HADDOW. I do, Mr. Chairman.

Chairman HEINZ. Well, then, I think you had better spend some time with the GAO, which has looked at it.

Mr. HADDOW. The GAO specifically—and you just heard the testimony—has not looked at our inpatient quality review studies. And that is the specific item you cited that I had referenced when we talked about being able to keep track of quality problems within the system. And I intend, Mr. Chairman, later in the statement, if we could proceed, to address specifically the issues that the committee staff has provided with respect to our ability to monitor quality of care.

If I might continue, with your permission.

Chairman HEINZ. Please do.

Mr. HADDOW. Thank you.

We welcome, Mr. Chairman, the opportunity provided by this hearing to assess our progress in maintaining the high standard of quality care that has been the hallmark of the medical care delivery system in this country. In that context, I would like to make several points that relate specifically to previous testimony and conclusions drawn from it by committee staff.

First, the practice of medicine is at its very best, only an imprecise art. With all of our best medical educational institutions, the advantage of broad clinical experience, the expertise of skilled specialists, and the most advanced medical technology known to man, there will be patients who will evidence symptoms that mask the disease or trauma that requires more intense, acute care intervention. And, on, occasion, mistakes in medical judgment, preventable or otherwise, will occur. The outcomes of these instances of misdiagnosis are sometimes evidenced in denial of admission to an acute care facility, a readmission after an inappropriate treatment episode in an acute care facility, or sadly, a possible fatality subseguent to a premature discharge. The plain fact is, such mistakes are part of the practice of medicine and occurred before the implementation of the prospective payment system, and will continue to be evidenced as a part of PPS as long as the etiology of diseases and their attendant cures elude us.

One significant advantage of PPS is that we are monitoring performance, keeping score, if you will, better than ever before, and that allows us to correct abusive patterns of practice by providers more effectively and more quickly than ever before. And beneficiaries are being protected from unnecessary admissions, unjustified surgical procedures and therapies, and unwarranted extended stays in hospitals, that protect them from increased risk of nosocomial, or hospital-based infections, errors in medication, excessive testing, and injuries from falls. And the emphasis on efficiency, which has facilitated our goal of restraining cost increases, has also encouraged providers to specialize in procedures where demand allows for development of enhanced surgical expertise.

In a study conducted reviewing 287,000 discharges from providers, focusing on high-volume DRG's, we saw a 13-percent increased survival rate of patients and a reduction of 4 million patient-days of hospitalization for those patients. Clearly, positive quality outcomes exist that flow directly from the incentives for efficiency inherent for PPS.

The second major point I would like to make relates to premature discharges of patients by providers. We have believed our most crucial objective under PPS has been to maintain quality and access to care for our beneficiaries. To accomplish this, Congress mandated and we have implemented, a strong medical review mechanism, the peer review organizations. The PRO's are working closely with us to refine our effectiveness in monitoring quality.

We have heard, Mr. Chairman, as has this committee, the anecdotal episodes of premature discharge. I have already reaffirmed our commitment to aggressively investigate and, where appropriate, to take strong and immediate action to correct the problem.

Aside from the mistakes that can occur in the practice of medicine, we are identifying and taking action against providers who engage in inappropriate patterns of practice and behavior.

But these anecdotal cases should not obscure the big picture. Of 8.6 million PPS discharges, our PRO's to date have identified 4,596 possible cases of premature discharge or incomplete care. Even if each proves to be a case requiring our action, they represent less than five one-hundredths of 1 percent of all discharges.

I should emphasize those numbers should not be viewed as the total universe of quality problems, but they clearly indicate that the conclusion that a systemic quality problem exists under PPS is simply unjustified.

In addition, we are refining the PRO review system. In the coming contract period, the proposed PRO scope of work would expand review to further address the potential for premature discharges. PRO's will be required to review all the admissions within 15 days of discharge, instead of within 7 days as required under the current scope of work. PRO's will be required to review a sample of all discharges to determine if premature discharge or inappropriate transfer has occurred. PRO's will be required to implement a generic quality screen to identify inadequate discharge planning, and PRO's will review hospital stays of short duration to assure that premature discharge did not occur and that the care provided during the stay was appropriate. As is currently required, in all cases in which a PRO finds poor quality, corrective action must be taken.

I read with some interest, Mr. Chairman, the testimony of representatives of PRO organizations advancing recommendations to significantly expand the scope and the number of admission and discharge reviews conducted by the PRO's. It is our belief that refinements outlined previously will in large measure allow for more effective PRO review.

I would simply remind the committee that each of these PRO organizations is a business which has contracted with HCFA to perform a specific set of services for an agreed-upon compensation package. While most of the PRO's are operating very well and meeting contractual obligations, there remains a margin for performance improvement for the industry as a whole before significant expansions of workload should reasoably be contemplated, even if we were convinced such an expansion were necessary and justified.

It goes without saying that any increase in workload would proportionately expand the profit potential of those PRO's as businesses, which certainly impairs their argument for expanded reviews.

I would like to stress that we monitor the PRO program very stringently, and take prompt action where we find deficiencies in performance. We have withheld money from several PRO's because of poor performance. If that performance is not corrected, we will terminate the PRO. For example, Mr. Chairman, in your own State of Pennsylvania, we terminated the original PRO and now have an effective successor in operation.

Now I would like to briefly discuss posthospital care, specifically skilled nursing facilities and home health care, how PPS may be impacting on it and how we assure quality in those settings.

Skilled nursing facility and home health agency benefits are important components of the Medicare Program, providing coverage of continued care when acute hospital care is no longer appropriate. The intent of the benefit has always been to prevent prolonged hospitalization. Since PPS has increased incentives to shorten hospital stays, we fully expected to see an increase in utilization of these services after PPS was implemented. In fact, our latest data indicates that there has been only a slight increase in utilization of skilled nursing facility care, 1.3 percent, and a 1.1 percent increase in home health care.

In your opening statement of October 24, 1985, in a hearing of this committee, Mr. Chairman, you stated the belief that: "HCFA repeatedly over the past months has misrepresented or withheld evidence of problems and abuses, presuming ignorance can replace the truth."

You cited our report to Congress that DRG's create no significant effect on hospital discharges on SNF's and HHA's. You specifically advanced the argument—I presume, based on statistical research provided by the committee staff—that since DRG's went into effect in October 1983, discharges to SNF's and HHA's have increased by almost 40 percent and 37 percent, respectively.

I would ask you to consider two specific responses. One, when the DRG's were implemented, the whole focus was to reduce unnecessary hospitalization and increase utilization of outpatient services when that level of care was more appropriate. The obvious outcome was to hospitalize only those patients who needed acute care treatment. It would follow, therefore, that the smaller number of patients requiring more intense acute care would increase the discharge destinations to SNF's and HHA's. The easy patients were handled under PPS in outpatient settings where prior to PPS they were part of a larger denominator of hospitalized patients who would not require any SNF or HHA care after discharge.

Second, the 40 and 37 percent increases at best convey a serious misimpression about increases in discharges to SNF's or HHA's. In fiscal year 1984, discharges to SNF's were 5.3 percent of all Medicare discharges. In fiscal year 1985, discharges to SNF's increased slightly, to 5.8 percent. Fiscal year 1984 discharges to HHA's were 3.1 percent of all Medicare discharges. In fiscal year 1985, that number increased to 3.8 percent.

Even if you do not factor the smaller denominator resulting from increased outpatient referrals, the numbers do not represent any significant change in discharge destination.

I am most concerned, Mr. Chairman, that those beneficiaries who rely so heavily upon us for accurate information will not have appropriate information upon which to make decisions regarding their health care choices.

Finally, Mr. Chairman, may I say that any definitive judgments about the overall impacts of PPS are premature. We remain committed to working cooperatively with the Congress to implement needed refinements in the prospective payment system. Where adjustments would allow us to more effectively serve Medicare beneficiaries within the scope of our mandate, we will administratively adjust, and seek your legislative assistance where appropriate.

The coming months will bring further reports, which will provide additional data upon which further refinements to the system will be evident. Our internal research and our cooperation with the Office of the Inspector General, with the General Accounting Office, and the Office of Technology Assessment, and with congressional committees, should occur in a spirit of cooperation to the extent possible.

Thank you, Mr. Chairman. I would be delighted to respond to any questions you might have.

[The prepared statement of Mr. Haddow follows:]

Prepared Statement of C. McClain Haddow

INTRODUCTION

Mr. Chairman and members of the Committee. I am pleased to be here today to discuss an issue of the utmost importance; the impact of the Perspective Payment System (PPS) on the quality or care provided to Medicare beneficiaries. We share this Committee's interest in assuring that the system is achieving its goal of providing medically necessary and appropriate care for our beneficiaries in a cost effective manner. The Committee has asked many pertinent questions and we are submitting the answers to these questions for the record. We appreciate your efforts, Mr. Chairman, in introducing legislation to provide us with the authority to further ensure that our beneficiaries receive quality care.

HEALTH CARE REVOLUTION

High quality medical care has a long-standing tradition in this nation. The Medicare program has played an important role in ensuring the quality of health care available to older Americans.

Today, the challenge is cost, and despite the pressures and the efforts to "apply the brakes" on spiraling health care costs, felt by every individual or group responsible for paying the bills, I do not believe that tradition is in jeopardy. What I believe we are seeing is a change in behavior, a revolution if you will, in the health care system—how services are delivered and how they are paid for. And everyone is involved; Consumer, providers and third party payrs alike. Consumers of health care services are becoming wiser shoppers, spending their health care dollar where they receive the most benefits; corporations and unions are revamping benefit packages to contain costs through use of HMOs, second surgical opinion programs and expert panels to review and predetermine what services will be covered and at what level of reimbursement. Insurance companies are changing their first dollar coverage plans to include deductible and coinsurance. And, they are advertising flexible benefit plans tailored to minimize premium costs.

We are also seeing fundamental changes in how health services are being delivered. More physicians are opting to provide services under salaried arranements through their involvement in HMOs and group practices rather than under the traditional fee for service mechanism. Physicians are becoming acutely aware of the costs of health care services and technologies they order for patients and are being asked to make judgements on the necessity of services. Changes are being seen in hospitals as they develop more cost effective methods for providing services and especially services involving high technology procedures. There is also evidence of a decrease in ancillary services within hospitals. Hospitals are moving away from the overutilization of services and the duplication or equipment that prevailed in the past. There is an increased sharing of services between providers, increased specilization of cases within hospitals which are best equipped to handle them, and greater competition among hospitals.

All of these events, and more are happening now within this nation's health care system.

PROSPECTIVE PAYMENT SYSTEM

An integral part of this dynamic revolution is the prospective payment system. There are few who would argue that the prospective payment system (PPS) was an innovation in reimbursement methods whose time had come.

For over 17 years, hospitals were reimbursd on a reasonable cost basis which failed to encourage efficiency since we reimbursed basically whatever costs were incurred. Under PPS, hospitals are provided a known payment—set in advance—that is based on the patient's diagnosis. There are a number of positive effects which result from a perspective system:

Patients are protected from incidents of unnecessary hospitalization, unnecessary surgical intervention and possible resulting infection;

Hospitals are rewarded for careful utilization of resources, as the system encourages management to organize and provide services in an efficient and cost-effective manner;

The system ensures greater predictability of revenue for the hospital.

The role of the Federal Government as a prudent buyer of services is reinforced.

Let me emphasize, that the complexity of the new payment system and its accompanying medical review requirement presented an enormous challenge to our Department. Although implementaton of PPS is moving into the third year of transition to a national rate and the Peer Review Organization (PRO) program is fully operational, that challenge has not ended.

To meet the demands of the constantly changing health care marketplace, we are continuing our ongoing activities to refine the prospective payment system to ensure that payment levels support delivery of quality care. It is also important to assure that reimbursement levels appropriately reflect labor costs which represent approximately 80 percent of a hospitals revenue. Consequently, we have already modified the wage index used to adjust the labor portion of the DRG rates. We are also studying other refinements such as adjusting the rates to account for severity of illness, and are invovled in a comprehensive research effort to determine how to recognize differences in severity among patients with similar diagnoses. We are also investigating how to deal equitably with rural hospitals which compete with closely neighboring hospitals in urban areas. And, we have undertaken an extensive research effort to enable us to define and address the issue of hospitals which serve a disproportionate share of low income and Medicare patients.

Concurrent with the positive changes PPS is expected to achieve there also exists, within the system, incentives for providers which could impact on the quality assurance of patient care. It is on this issue—quality of patient care that I'd like to focus today.

QUALITY OF CARE

Just as PPS is a new system necessitating adjustments as it progresses, PROs will change to conform with these adjustments.

The most crucial objective throughout the payment reform process has been to maintain quality and access to care for our beneficiaries. To accomplish this, Congress enacted a strong, medical review mechanism. The PRO amendments of 1982 put this mechanism in place and the Administration has implemented it with vigor.

Let me emphasize here, Mr. Chairman, that this ia a unique time in our pursuit of quality care for Medicare's beneficiaries. We know more about quality assurance now than we did under the cost reimbursement system. We are collecting more data and we are spending more time and money on quality assurance than at any other time in the history of the Medicare program. We believe that PROs will not only continue to ensure that quality Medicare care is delivered in this country's hospitals and that payments continue to be appropriate.

PROPOSED PRO SCOPE OF WORK

The PRO's proposed scope of work for the coming contract period addresses many of the concerns we've faced this year. I would like to speak to these briefly.

PREMATURE DISCHARGE

A major concern both of Congress and the Administration has been the potential for premature discharge under PPS. Under the current scope of work PROs are required to review all cases of readmission to a hospital within seven days of a discharge to determine if the readmission is a result of inappropriate care or premature discharge on the first admission. And PROs have been directed to deny payment to the hospital for a second admission when that readmission is determined to be the result of inappropriate care or premature discharge.

I might add, Mr. Chairman, that in addition to this review, PROs have reviewed 34 percent of all discharges through August of 1985, for a cumulative total of about 3,360,000 cases since they began review.

Although data indicate that a systemic problem does not exist, we have heard, as has this Committee, anecdotal episodes of premature discharge. These episodes are traumatic to the individuals involved ant totally unacceptable to this Administration. While it is unrealistic to expect that we can eliminate all such instances of poor quality of care, when we learn of them, we will take immediate action and we are using this anecdotal information to further refine PRO review. We would encourage this Committee to continue to make us aware of all such cases in order that we can take appropriate action.

In the coming contract period for PROs, the proposed scope of work would expand review to prevent premature discharge in the following ways:

PROs will be required to review all readmissions within 15 days of discharge;

PROs will be required to review a sample of all discharges to ascertain whether premature discharge or inappropriate transfer occurred;

PROs will be required to implement a generic quality screen to identify inadequate discharge planning; and

PROs will review short hospital stays to assure that premature discharge did not occur and that the care provided during the stay was appropriate and of adequate quality.

As is currently required, in all cases where a PRO finds poor quality, corrective action must be taken, ranging from education of the individual physician or hospital, to intensified review, to payment denials where actions are taken to circumvent PPS, and ultimately to exclusion from the Medicare program. It is important to understand, that without PRO review, these sanctions would not be possible.

PROs will also continue to review transfers to another PPS hospital, exempt units and swing beds to ensure that these transfers are appropriate.

Concerns have also arisen about the quality of care for Medicare beneficiaries:

Whose surgical procedures have been shifted from inpatient to the outpatient setting, and

Who receive care through a Medicare approved HMO.

We are currently exploring the advisability of expanding PRO review to these areas.

PATIENT'S RIGHTS

Another area that has concerned us is the continuing misunderstanding by some about PPS, PRO review, and the rights of patients of an appeal. We believe part of this problem is related to beneficiaries not clearly understanding the entire PPS process, although we have worked to our utmost to assure their full awareness. Several HCFA publications explain PPS, PROs and a beneficiary's appeal rights. In addition, HCFA worked closely with the American Association of Retired Persons (AARP) to develop a publication on patient's rights under PPS.

We will continue to work with groups interested in developing similar publications. We would also include in the new PRO scope of work, a community outreach program to help beneficiaries understand the role of the PRO and their appeals rights.

In addition to these efforts, hospitals are required to inform patients of the purpose of PRO review and their rights of appeal. Anecdotal information indicates that this is not always happening. We are currently developing plans to assure that beneficiaries are informed of their rights while in the hospital. In addition, we recently informed PROs, through our regional offices, that PROs must provide specific language to hospitals which the hospitals must use to inform beneficiaries of the existence of the PROs, the fact that the PRO may review care provided, and the right of the beneficiary to appeal a decision by the PRO with which he disagrees.

We believe that an informed consumer can do more to protect his or her own rights and to influence the efficiency of the health care system than any government action. We will use every avenue available to us to assist our beneficiaries in becoming their own best advocate. And, we hope that the media covering this hearing will join with us in educating Medicare beneficiaries of their rights. We certainly will not rest until every effort has been made to do so.

MONITORING OF PRO PERFORMANCE

In addition to making refinements in PPS and PRO review, we are closely monitoring what PPS and PRO review actually means to the Medicare patient. We want to know for instance how PROs are functioning to assure quality of care for Medicare beneficiaries. One way we are doing this is through the SuperPRO. The SuperPRO is an organization of health care professionals whose reports will provide us with an unbiased evaluation of PRO performance, e.g., is the PRO making correct determinations regarding a patients admission and need for continued stay, is the PRO conducting all areas of review properly? Preliminary reports for the first 6 months of PRO operations have been received from SuperPRO and are currently being analyzed. Final reports for that period are due early in December.

I would like to stress that we monitor the PRO program very stringently and take prompt action where we find deficiencies in performance. We have withheld money from several PROs because of poor performance. If that poor performance is not corrected, we will terminate that PRO. For example, Mr. Chairman, in your own State of Pennsylvania, we terminated the original PRO and now have a successor in operation.

In addition to the functions of PROs and the SuperPRO and what they tell us about the impact of PPS on Medicare beneficiaries, we are independently looking at this impact on patient care through five separate quality of care evaluations. One of these studies, being conducted by our Office of Research and Demonstrations, is to detect broad PPS related effects on quality of care by examining the outcomes of hospital care on the health status of patients.

In addition, we have contracted with health care research firms for completion of the other four:

A study by the Commission on Professional and Hospital Activities to measure the general effects of PPS on the quality of inpatient hospital care primarily by examining changes in hospital usage and treatment patterns, and their effects on inpatient and discharge status;

Two studies by Rand Corporation:

A study to evaluate the impact of PPS on the quality of care by assessing potential effects on changes in inpatient hospital treatment patterns through a thorough examination of the medical record, and resultant health status outcomes; and

A study to investigate the feasibility of using Medicare (non-intrusive outcome) administrative data to detect quality of care levels within individual hospitals; and

A study by the Urban Institute to evaluate PPS quality impacts on ESRD Medicare beneficiaries, a subset of the Medicare population generally assumed to represent an unusually high medical risk group.

We expect that each of these studies will provide further information on;

Where PPS is working well;

How it needs to be changed to work better; and

How PRO review shold be refined.

MONITORING—SURVEY AND CERTIFICATION

Our concern for access and quality, however, extends beyond PRO hospital review. We have a number of measures in place that further underscore our commitment to maintaining the highest possible level of quality care. The survey and certification program protects the health and safety:

of beneficiaries in Medicare facilities, such as hospitals and skilled nursing facilities (SNFs); and

of beneficiaries who receive home care through a certified home health agency.

States accomplish this survey function for the Medicare program. Through cooperative efforts with the Joint Commission on the Accreditation of Hospitals and the State Survey and Certification Agencies, this program works to uphold the standards and conditions for participating in the Medicare program. In this process, we have found that hospitals are not compromising their standards of care.

In anticipation of the unique incentives under PPS, we recently modified the survey process for SNFs and HHAs, to focus more closely on patient outcome. The modified survey process for SNFs, currently being tested on a limited basis in each State, focuses on the patient—what are the patient's needs, have services been ordered by the physician to meet those needs, and are the services being delivered as ordered.

In addition, we expect, in the near future, to require State survey agencies to begin home visits to determine the efficacy of care delivered to our beneficiaries in the home setting. The coverage compliance review program for HHAs has been strengthened by instituting similar visits by intermediaries into the homes of a sample of beneficiaries to assure provision of appropriate care.

Medical review of admissions to SNFs by fiscal intermediaries has also been strengthened in order to assure that Medicare beneficiaries are not inappropriately admitted to SNFs. The intermediaries have been working closely with providers to assure that there is a clear understanding of applicable coverage criteria.

Additionally, fiscal intermediaries and carriers are evaluated to assure that medical review determinations are accurate and are in conformance with HCFA guidelines and instructions. These checks protect older Americans from inaccurate determinations by the intermediary.

POST-HOSPITAL CARE

Skilled Nursing Facility (SNF) and Home Health Agency (HHA) benefits are important components of the Medicare program and we are committed to administering these benefits as intended by Congress. By providing Medicare coverage of acute hospital care, SNF care, and home health care Congress recognized that, in the treatment of illness, varying levels of care were often appropriate in order to provide continuity of care. The PPS has enhanced the "continnum of care" concept, which was also intended to assure that covered care would be rendered in the most economical setting consistent with the provision of quality care.

Medicare and HHA payments are for services to those beneficiaries whose conditions are of such severity that the individuals are under the care of a physician and in need of skilled nursing care. Patients are discharged from acute care hospitals to SNFs and HHAs based on the physician's recommendation that the patient is medically stable for subacute level of care.

The care in these post-hospital settings must be prescribed by a physician, thus ensuring the continuity of physician oversight. Additionally, services must be provided by a participating agency or facility in accordance with the physician's treatment plan.

This is exactly what we've seen. The prospective payment system has increased incentives to shorten hospital stays. However, the intent of post-hospital care has always been to avoid prolonged hospitalization. The number of SNFs and HHAs certified under the Medicare program has increased at about the same rates as admissions to SNFs and home care visits. In fact, the percentage increase in SNF admissions has been mirrored by the increase in certified facilities. Both have increased by about 20 percent. Home health visits per beneficiary have also increased at about the same rate, as certified agencies. Home health care is one of the most rapidly growing benefits covered by Medicare. HCFA expenditures for these services have increased by 1,000 percent since 1975. The growth in the number of providers demonstrates that increased demand for these services is being met. For example, the number of HHAs has increased from 3,639 in 1982 to 5,820 so far this year. The number of Medicare only certified SNFs increased from 276 to 443 and the number of dually certified, i.e., Medicare and Medicaid SNFs, rose from 5,233 to 5,748 during this same period.

We believe that these Medicare benefits are being administered in a manner wholly consistent with the intent of Congress, both in the statutory language and in the legislative history of the benefits. Our payment experience has been consistent and there has been no reduction of coverge as a result of PPS. We believe, in fact, that the operation of PPS will increase the likeilhood that patients, will receive post-hospital services at a point in their recovery where that care is appropriate. We will continue to monitor trends in SNF and home health care utilization in order to assure that this is the case.

In addition, we believe that greater conformity in the application of rules and in the administration of existing home health coverage policy will be achieved as a result of our having decreased the number of fiscal intermediaries from 47 to 10 as directed by Congress.

CONCLUSION

In conclusion, let me say that we are extremely pleased with the progress of the prospective payment system and the performance of peer review organizations in assuring that high quality care is maintained. This success is shared by providers, and physicians whose efforts contributed significantly to the smooth implementation of the program. As with any innovative program, no matter how well thought out, there are always wrinkles to iron out. The effects of PPS on quality of care will continue to emerge over time. Where these effects have a negative impact, we will move swiftly to correct them as we have in the past.

Responsibility to ensure quality of care, however, does not rest solely with the government. It is a responsibility which must be shared with the physicians, and consumers. We look forward to continued cooperation in our shared goal of ensuring that every patient receives high quality, medically necessary care. I will be happy to answer any questions you may have.

Chairman HEINZ. Mr. Haddow, first, I want to make clear for the record that the subpoena served on you on Friday was for documents, in your possession and in the prossession of HCFA. The committee staff had attempted unsuccessfully to get cooperation from the Health Care Financing Agency on these overdue reports for some months. And so it became necessary to issue a subpoena. We just wanted the documents, but we needed you, as acting administrator, to produce them.

And we thank you for at last giving us those documents.

So, our intention was not to make a show off of this.

Mr. HADDOW. I understand that, Mr. Chairman. I am told by my staff that the request for the eight research proposals by the PRO's was first evidenced to us on Friday, not ever before, and we would have gladly provided them on Friday had the subpoena not preempted our ability to do so.

Chairman HEINZ. Well, we can argue about that but of misinformation later.

As I listen to your testimony, I am encouraged, and I am puzzled by it. I guess I am encouraged by the fact that you say it is important under PPS to maintain the quality and access to care for our beneficiaries, and that you believe the PPS is in need of adjustments.

Mr. HADDOW. That is correct.

Chairman HEINZ. So far, so good.

Mr. HADDOW. Yes.

Chairman HEINZ. In that vein, as I said in my opening statement, there are really two ways to go about dealing with the prospective payment system. You can work with the Congress or you can ignore the Congress. It would be much better for all concerned if we in Congress really could work with the Health Care Financing Administration, because I am one of those people who would like to see the prospective payment system work. I do not want to see it dismantled. But I have grave concerns that unless we do work together, and unless HCFA is able to provide adequate data to track what is happening and to establish the reasons why what is happening is in fact happening, that we will end up so far apart that Congress may say that the system is unworkable and is jeopardizing the quality of care for patients. In that case, we are likely to end up with some other kind of system that is neither going to serve Medicare beneficiaries or the cost containment effort that we would like to see succeed.

What worries me, are some of the statements you make in your testimony. In your prepared statement on page 6, you state that, "We, HCFA, are collecting more data, and we are spending more time and money on quality assurance than at any other time in the history of the Medicare Program."

Now, is that supposed to mean that HCFA and the PRO's have all the data and resources and funding necessary for quality assurance?

Mr. HADDOW. Mr. Chairman, there is a philosophical issue at question here, and that is whether we want to embark on a system that tracks every beneficiary as they enter the health care delivery system. We do not believe that it is appropriate or necessary to have concurrent review for 100 percent of Medicare care that is delivered. Such a system would be cumbersome, would be difficult to implement and extremely expensive to the Americn taxpayers.

We do not think that the American health care system is in jeopardy of delivering poor quality of care. We believe that monitoring of inpatient hospital care is an essential component of identifying whether problems exist beyond on an anecodotal basis. We expect to aggressively continue to monitor that kind of inpatient hospital situation.

The question as to what kinds of studies can be conducted, looking at posthospital care, is the next stage for us to look at. We made an allocative decision to emphasize our research efforts on making a determination whether appropriate care was delivered to patients who needed acute care in hospitals. We are doing that; we are doing it effectively, and we are spending a large amount of resources both on a personnel level and financially in order to accomplish that goal.

So in answer to your question, yes, I think we are spending money at higher rates than we ever have before in an effort to determine from an adequate data base whether or not inpatient hospital care quality is being maintained under the prospective payment system.

Chairman HEINZ. That was not my question.

Mr. HADDOW. Well——

Chairman HEINZ. I was not questioning whether you were spending more money. I was asking you if you were getting all the data you think you need to be ensure quality of care.

Mr. HADDOW. Absolutely. Now, that is not to say that there is not more data that is going to flow from the existing studies that is not readily apparent to the committee here today. The GAO information relates to posthospital care studies.

We have significant amounts of data being collected right now on inpatient quality measures that are ongoing at HCFA that we would be delighted to share with the committee and with the Congress as that information becomes available.

Chairman HEINZ. You are satisfied with HCFA's existing quality of care review system?

Mr. HADDOW. On inpatient hospitalization, we have significant studies ongoing. Once the data is available to us, Mr. Chairman, obviously, it may lead us to conclude that we need additional data. But we cannot look into a crystal ball and make that determination in advance. Through our statistical data, we are seeing some very interesting things evidenced by the prospective payment system that we did not expect.

We did not expect a decrease in admissions. We did not expect that we would see specialization in providers that would actually enhance the quality of care that is delivered to Medicare beneficiaries as evidenced by the study I mentioned to you of a 13-percent increase in survival and 4 million fewer patient-days. That is something that comes from the data base.

Chairman Heinz. You mention a decrease in admissions. Have you any evidence to suggest one way or the other whether people who are being denied admissions, in fact, are being inappropriately denied admission?

Mr. Haddow. It is possible that when we do a screen for preadmission review—some PRO's are participating in 100 percent preadmission—review, that we will be able to identify a provider that is inappropriately denying admissions. But we do not believe on available evidence that it is a systemic problem—it occurs.

Chairman Heinz. Well, let us just look at the term, "preadmission review." Now, to somebody who is not familiar with all the intricacies of our health care delivery system and the inner workings of peer review organizations, that is a pretty impressive term. It implies somebody is looking at individual patients and assessing whether or not that individual should or should not be admitted to a hospital. That is what it implies. But you and I know that——

Mr. Haddow. That is what it is.

Chairman Heinz. That is not what it is. None of these reviews are made real-time. These are pieces of paper, pieces of paper that are looked at. Does one of the physicians in the PRO actually look at a patient? More importantly, do they actually look at the patient who did not get in?

Mr. Haddow. Mr. Chairman, there was never any intent, I believe, to the Congress——

Chairman Heinz. Just answer—I just asked a question. Do they look at people or paper?

Mr. Haddow. Do they stand and look over the shoulder of the doctor? No. Do they look at medical records? Yes.

Chairman Heinz. OK. Do they look at paper.

Mr. Haddow. They look at medical records.

Chairman Heinz. And second, do they review the medical records of someone who was not admitted?

Mr. Haddow. On preadmission reviewed, yes. They determine whether an admission was justified, or a deniable admission was justified, yes. They look very closely at that.

Chairman Heinz. On average, how thorough is the review of the patient records of those people who are denied admission? Would you care to describe that process?

Mr. Haddow. I would love to. I think that it is very important to recognize that we do not believe there is any systemic problem. Doctors make medical judgments about whether patients should be admitted to the hospital or not. And——

Chairman Heinz. I understand what you believe. What I am trying to get at is the process you use. I just want the facts.

Mr. HADDOW. On an individual case, the PRO would talk to the doctor after looking at the medical record to make a determination as to why the doctor elected not to admit a patient.

Chairman HEINZ. In what proportion of cases does the PRO talk to a doctor about that?

Mr. HADDOW. It is not very high, because there are not that many cases of denied admissions that are challenged. We do not think there is a systemic problem here, Mr. Chairman. We said clearly—that if there were, then perhaps a second opinion on all admissions would be justified. But we do not think that the medical system is in such disarray, and that it is pandering to make money to the extent that it would require admissions virtually out of hand.

We believe that the prospective payment system addressed a very significant overutilization problem of acute care facilities that was bankrupting the Medicare trust fund.

Chairman HEINZ. You yourself mentioned that there has been a substantial decrease in hospital admissions.

Mr. HADDOW. That is correct.

Chairman HEINZ. And maybe some or a good deal of that is justified.

Mr. HADDOW. That is correct.

Chairman HEINZ. And maybe some—and maybe a good deal of it—is not. We do not know. The reason we do not know is that when someone is turned away from the hospital door, by the doctor—not the hospital, but by the doctor—that information does not go to the PRO.

Mr. HADDOW. Mr. Chairman, that is why——

Chairman HEINZ. PRO's do not review decisions of physicians.

Mr. HADDOW. That is why we are changing the scope of work. We did not anticipate with the new system that there would be a necessity for reviewing admissions, because we thought the admissions would go up. We believed that the behavior would evidence itself in increased admissions under the prospective payment system. We saw a decrease in them, and that is why we are changing the PRO scope of work.

It is clearly the fact in the medical care delivery system that admission rates for patients under 65 are falling as well. The behavior in the entire medical marketplace is drastically changing; it is being revolutionized. And obviously, medical providers are making the same decisions about non-Medicare patients as they are about Medicare patients.

We are becoming more efficient, more cost-effective, and we are maintaining the high quality of care that has been the hallmark of our system.

Chairman HEINZ. Earlier, you indicated that the anecdotal episodes of premature discharges are totally unacceptable. As a matter of fact, at the beginning of your statement, you indicated that what you would like to do more than anything else is to disprove that any of the anecdotal cases were true. That is commitment.

You also state that it is unrealistic to expect that we can eliminate all such instances of poor quality care.

Now, my question to you is what does HCFA consider to be realistic, if it is unrealistic to eliminate all these instances of premature discharge and inappropriate transfers? What is the standard for acceptable or realistic performance?

Mr. HADDOW. Mr. Chairman, as we look at the actual numbers of cases that are suspected quality abuse cases, and as we look at the number of discharges as in comparison to that, as I indicated in my testimony, we are looking at less than five one-hundredths of 1 percent of the suspected cases of quality abuse.

One is too many. And that is why the PROs are in place. They will look at every case of suspected quality abuse that is referred to them.

I am prepared to deliver on our commitment to investigate any that the committee staff provide to us. We found one that was submitted for testimony that we were able to get specific information on that was purely inaccurate, and that involved the case of Mrs. Kratt and her doctor, Dr. Kellawan. We think that the information provided to the committee there, as our PRO has investigated the facts, simply did not measure up.

Mrs. Kratt said that the physician was out of town at the time of the discharge, and that it was done without his approval. That turns out not to be the case. Dr. Kellawan signed the discharge order. It was a medical judgment. And we think on that basis, the committee was given bad information.

Chairman HEINZ. Let me ask you about something you have just said in respect to the bigger picture. You said that premature discharges are referred to the PRO's if someone decides to refer them. That is what you said, right?

Mr. HADDOW. That is correct.

Chairman HEINZ. Who makes the decision to refer them?

Mr. HADDOW. Well, the PRO actually looks at a large number of the discharges that are done. We look at the readmissions that are a good indicator of inappropriate care. Our new PRO scope of work expands that from 7 days to 15 days. We look at 100 percent of all complaints that are brought by beneficiaries.

One of the areas that we want to strengthen in the new PRO scope of work is to expand our community outreach to ensure that every Medicare beneficiary who enters a hospital will know what his or her specific rights are. We have been dissatisfied with PRO performance on this level. Hospitals are required to provide that notice of appeal right to a Medicare beneficiary upon entering the hospital. We are going to strengthen the PRO monitoring of that.

Chairman HEINZ. I am glad to hear that. We will get to that in a moment. Again, when one says that the PRO's investigate 100 percent of all complaints, the problem is that the PRO has to receive a complaint. We all know how complicated the PRO review system is right now and how uninformed patients are of their rights to appeal, to complain——

Mr. HADDOW. And that is why we are strengthening that.

Chairman HEINZ [continuing]. And you do not contest that, I do not think.

Mr. HADDOW. We are strengthening the procedures. Hospitals are required to provide to each beneficiary upon admission to a hospital a statement of their rights and PRO's are to closely monitor that. I have recently written to AMPRA and our regional office (which monitor PRO's) to give them specific instructions about what information hospitals should provide. And we are developing model language to assist in clearly stating to the beneficiaries what their rights are. We have cooperated with the American Association of Retired Persons in the development of a brochure entitled "Know Your Rights." And we think that we have a little work left to do that will enhance the ability of a beneficiary to understand clearly what his or her rights are in inpatient hospital care decisions with which he or she does not agree.

Chairman HEINZ. As I understand your earlier testimony when you were talking about the 8.6 million discharges under PPS, isn't it true that only about a third of those discharges are reviewed for any purpose whatseover?

Mr. HADDOW. About 46 percent of them.

Chairman HEINZ. OK.

Second, is it not true that the vast majority of that number are reviewed only for utilization purposes, that is to say, cost containment purposes?

Mr. HADDOW. Well, Mr. Chairman, many of the reviews that we do, generic screens that we have particularly proposed for the new scope of work, were designed because we believed that utilization was our problem—overutilization. I have already indicated to the committee——

Chairman HEINZ. I am not saying that utilization review is inappropriate. I am just trying to get an answer to my question.

Mr. HADDOW. My point is that the new scope of work clearly looks at that question of focusing on the discharges. We want to now look at—and we do 100 percent of related readmissions within 7 days right now—we want to focus on inappropriate care by providers——

Chairman HEINZ. Well, 100 percent of all readmissions within 7 days, and you are expanding that to 15 days.

Mr. HADDOW. To 15 days, yes. We are refining the scope of work; there is no question about that.

Chairman HEINZ. Patients who are DRG losers and who are discharged from a hospital and go someplace else—as apparently they do in Cook County and Cuyahoga County, to those municipal hospitals there—are not caught in that screen.

Mr. HADDOW. That is not accurate, Mr. Chairman. The only occasion in which that would be true is if the patient's readmissions were to a provider outside of the original PRO area.

It is true that we would not be able to deny the payment for the second admission if someone sought care at an alternate facility. But we certainly can look at and do look at identified quality issues that are involved and put the provider under intensified review, which virtually signals them that we are going to look at 100 percent of their cases if they engage in an inappropriate pattern of practice. It is not accurate to say that we do not routinely catch patients who are readmitted to a second facility, unless in limited cases, they go outside of the PRO area or the fiscal intermediary that covers them.

Chairman HEINZ. When you say you do not catch them, do you mean you do not catch them for inappropriate discharge and quality issues, or you do not catch them for cost containment——

Mr. HADDOW. We do not catch them on the sanction. We catch them on the inappropriate care if it is a quality problem. We look at all related readmissions within 7 days, 100 percent of them, with the exception of, as I said, outside the PRO area or the geographic boundaries of the fiscal intermediary.

We may not be able then to issue the sanction, the cost, not allowing payment for the readmission, but we certainly can investigate the provider and the inappropriate care that was delivered in the first instance.

Chairman HEINZ. The organizations that you rely on for all this work are the Peer Review Organizations. You give great credibility to these profit making organizations when their information supports your position. But when they say, as does Dr. Dehn, who is the president of the American Medical Peer Review Organization Association, that the PRO's are hamstrung by what they consider to be restrictive, underfunded, relatively inflexible and too narrowly focused programs for quality assurance, you dismiss that as being a self-serving statement by a profitmaking organization, the claims and statements which are not to be attributed any credibility because they are profitmaking organizations.

Mr. HADDOW. Mr. Chairman, I simply indicate to you that for the specified contractual services we ask the PRO's to perform for us, we are getting the data we are asking for. There are some performance problems in individual PRO's, but we are satisfied that, overall, they seem to be working well.

I merely indicate to you that from a public policy standpoint, I believe it is inappropriate to look to the PRO's as an angel of mercy when in fact, the AMPRA proposal to expand review inures to their financial benefit. And I would think that the public policy decisions should be reserved to the Congress and, where administratively delegated, to the Department of Health and Human Services, with the benefit of the PRO's advice, but certainly this should not be the controlling factor since the basis of their opinions is so clearly tainted by a profit motive.

Chairman HEINZ. Can you have it both ways?

Mr. HADDOW. Well, Mr. Chairman, the reason I made that delineation is I do not want to have it both ways. I want to receive a contracted service from the PRO's. I do not think it is appropriate for them to be advocating expanded review, 100 percent concurrent review of all Medicare beneficiaries, when that involves substantial public policy, decisionmaking. Such decisions are properly left to those who have the public responsibility and are answerable to the American population and citizenry, rather than to a group of stockholders who may be concerned about the bottom line of the PRO.

Chairman HEINZ. If you believe what you just said, let me make an equally credible statement, which is that the people who buy the services from PRO's are prudent purchasers and only want to get what they want. This is because if they are going to pay the bills of the PRO's, as does HCFA, you are only going to want what supports your contention.

Mr. HADDOW. We do not expect them to provide services beyond the scope of the contract that we have paid them for, absolutely. They are not in the welfare business.

Chairman HEINZ. So let us go one step further. If the PRO's are profitmaking organizations, as you contend, then it is going to take them a long time to find quality problems. Quality assurance is time consuming and potentially expensive. If you want to just take a piece of paper, stamp it, move it along, it does not take much time

It would seem to me the profit motive really operates to prevent the PRO's from doing the kind of quality assurance job that you claim that they can do. They, of course, claim that they cannot do the kind of job that you say you want them to do, and you say they cannot be trusted to do it.

Mr. HADDOW. There are specific controls. There are contractual responsibilities; there are performance standards which we have set. We do not allow PRO's to be processing plants. We expect them to do quality reviews. Where we find that a PRO is incapable of meeting its contractual obligation, we terminate it. That is evidenced by the case in your home State, Mr. Chairman; it has been done in Massachusetts, and it has been done in South Carolina. We are aggressively monitoring the quality of care. We set specific performance standards. We do not let them slough that responsibility, and we have a capability of analyzing their performance with a super-PRO, which is a company called Systemetrics, which every 6 months analyzes randomly approximately 400 cases of each PRO to determine whether or not it is meeting its contractual obligation to analyze quality.

We think this system is working very, very well. I do not mean to denigrate the PRO's. I think that we should just simply understand what their role is, and when we look at the policy kinds of recommendations that they make, we should view them for what they are and certainly take them under consideration, but not let them be the definitive reason for us to move willy-nilly into 100 percent concurrent review of Medicare beneficiary treatment in acute care settings.

Chairman HEINZ. You know, if I had to choose between you and the PRO's, I think I would have to trust the PRO's. I will tell you why——

Mr. HADDOW. I am sorry to hear that, Mr. Chairman, because it denigrates the HCFA professionals——

Chairman HEINZ. No, you should not be sorry. You should listen to what I am about to say, because I will give you a reason.

Let us assume that Dr. Dehn, a physician, is tainted by the profit motive. In spite of that fact, he, on behalf of the association, indicated quite publicly and emphatically on at least two occasions that even in the case of premature discharges that they, the PRO's, do not know what is happening. They are saying, "We do not know what is happening." And you are saying, "Not to worry," because that is self-interest, that is the profit motive. They come before Congress and embarrass themselves, but they cannot be trusted.

Mr. HADDOW. Mr. Chairman——

Chairman HEINZ. But let us say that you are right. Let us say that anybody who works in the private sector cannot be trusted. That is only about 104 million Americans.

Mr. HADDOW. That is not what I said, Mr. Chairman.

Chairman HEINZ. The Office of Technology Assessment in a report released last month criticized HCFA's effort to study the prospective payment system impacts. And only a few moments ago, we heard the GAO witness state that your agency has not yet developed the data to measure the prospective payment impact.

In the face of all that, what you are saying is, "Everything is fine." I guess you are entitled to say that. You are entitled to listen to a lot of expert testimony from the Office of Technology Assessment, from the General Accounting Office, from your own watchdogs, and if you do not want to believe any of it, I guess there is nothing we can do about it.

Mr. HADDOW. Mr. Chairman, that is not what I said. I think clearly, if we step back from the specific cases that we have been discussing and the specific points of the testimony, that HCFA supports expanded PRO quality review. That is evidenced in our expanded scope of work. We want to refine the system. We made some mistakes early on in trying to predict what the behavior of a very new system would be, of a very complex marketplace in health care delivery services. We support expanded PRO quality review, not to the extent that some might ask us to do because we do not think it is justified with the preliminary data available to us.

Second, we support beneficiaries needing to know and having greater access to information about their rights.

And third, we support expanded payment reform in the future as it relates to posthospital discharges. Clearly, we are in agreement on many of these issues.

But I believe that it is inappropriate to draw the conclusion from my statement about PRO's that I think that PRO's are bad, or that the entire marketplace is bad. Obviously, there are outcomes that are very beneficial. I simply suggest that because the PRO says we ought to have 100 percent concurrent review of Medicare beneficiaries with access to acute care settings, that we should not then assume it is appropriate. We should look at it, we should analyze it, and then make decisions about how the contracts will be awarded in the future.

They are doing an excellent job overall. They would like to do more; I know they would. We do not believe as a public policy decision that it is warranted, given the present data, particularly as we look at the evidence on premature discharges. That evidence is there, Mr. Chairman, and I know sometimes it gets extrapolated and misused.

Your own evidence and statement regarding the discharge destination from SNF's to HHA's clearly says that there was a 37-percent increase in discharges to HHA's and a 40-percent increase in SNF's. I think that that statement is designed to create fear in the hearts of the fragile Americans that we serve.

And yet, if you look at the chart, as a percentage of the overall number of patients who leave the hospital, 4.4 percent in fiscal year 1984 increased to 5.8 percent in 1985. In HHA's, it was 2.7 to 3.8.

Now, certainly, the statistical aberration of 4.4 to 5.8 is a 40-percent increase—a little less than that, actually—but it is still insignificant in terms of destination discharges.

The truth is that as a percentage of total Medicare beneficiaries, even if you do not accept my argument that the denominator is much smaller, having screened out the easy patients and outpatient settings, there is no reason for the conclusion to be drawn by this committee or anyone else that there is a 37-percent increase in HHA utilization or a 40-percent increase, specifically because it conveys to the American public a misimpression of what is actually happening in the marketplace.

Chairman HEINZ. I am going to yield to Senator Bingaman in just a minute, but I am glad you brought this up. First, the 40-percent is based not on my data, but on your own agency's data, and——

Mr. HADDOW. It is right there, Mr. Chairman.

Chairman HEINZ. I know it is there. And what you are seeing in that chart is one analysis that shows that skilled nursing home, on the left, and home health agency admissions have risen; both have increased by about 20 percent, right? Do we agree on that?

Mr. HADDOW. Mr. Chairman, a difference between 4.4 percent for SNF's in fiscal year 1984, and 5.8 in 1985, if you look at the difference in the increase between 4.4 and 5.8, you are correct. But the impression that is left is that there is this massive increase in utilization of SNF's, and as a percentage of the total discharges, my point is that of 100 percent of the discharges, only 5.8 percent of the people in fiscal year 1985 that were discharged went to a skilled nursing facility as opposed to 4.4 percent. And it is the impression that is left that I object to.

There is an attempt, I believe, by the people who looked at those figures to convey to the American public, particularly to Medicare beneficiaries, the false impression that we are overutilizing or creating a great strain on the resources that are available under SNF's or HHA's. My only point is that we have to deal with the real world——

Chairman HEINZ. You do not consider a 20-percent increase a significant increase?

Mr. HADDOW. I do not consider a 4.4- to 5.8-percent increase in the total universe of 100 percent of all discharges to be significant, no, sir.

Chairman HEINZ. You do not consider the difference between 100,000 and 120,000 to be a significant increase?

Mr. HADDOW. In the context of your 37-percent and 40-percent figures, no, sir. In the context of what it means for care——

Chairman HEINZ. We will get to those 37 and 40 percent figures. There is a technique that the Health Care Financing Agency uses for coming up with these particular numbers which personally, I believe significantly under-represents the demand on skilled nursing homes and home health agencies, and it is this. Your numbers are based on skilled nursing facility billings to Medicare. Now, that may not sound like a significant number, but billings to Medicare have been increasingly limited by a series of changes in HCFA regulations. As a result, a lot of Medicare beneficiaries are having a great deal more difficulty getting care today than in previous years because of the stringent HCFA policy limiting those kinds of services.

The discharges to skilled nursing facilities indeed are, in fact, substantially greater than those numbers represent. The problem is that you have only recognized about half of the numbers of increase as being reimbursable under Medicare. That is called a change in the counting rules. If you change the counting rules, as indeed these numbers, I believe, accurately reflect that change, you are going to get a very different picture. It is the difference between taking a picture with a wide-angle lens and then saying here is the world out there, and then quickly putting on a little, narrow telephoto lens that leaves out half of the picture that you took before. That is what these numbers represent.

Isn't it true that the Health Care Financing Administration has really tightened up?

Mr. **Haddow**. It is as you say, Mr. Chairman—you cannot have it both ways. The Office of the Inspector General estimated that we were expending about 27 percent of our home health agency moneys inappropriately for noncovered Medicare services. Now, we did not believe that the number was that high, but it certainly called for us to act to review administratively whether appropriate Medicare-covered services were being delivered to Medicare beneficiaries. So yes, we have administratively refined the system.

Chairman **Heinz**. That may be all well and good. But what we want to measure is apples and apples, not apples and oranges. If you are going to measure change, it is important that you use the same measurement criteria from 1 day to the next. Maybe HCFA was doing a terrible job, maybe they were doing a fine job before you came along—you have been there how long now?

Mr. **Haddow**. Since August. But I have been with the Department for 2½ years, Mr. Chairman, and understand oversight responsibility.

Chairman **Heinz**. I understand. But the question is what is the increase in discharges to skilled nursing facilities and home health agencies. You cannot have it both ways. You cannot say, well, we were doing a bad job, and we have changed the rules, and so we have a new method of counting; we do not count apples anymore, we count walnuts. By the walnut method of counting, we are only up 20 percent. What you should do is go back and count the walnuts that you had before the changes in the rules. Let us find out how many walnuts would have been countable under the old system.

Mr. **Haddow**. I accept that, and I think one standard we might use is the discharge data that relates to the number of Medicare beneficiaries per 1,000 who are discharged from acute care settings who go to SNF's, and I think even under that standard, it is 19.1 per 1,000 in 1983, and I believe it went up to 19.9 per 1,000 in 1984. Those are discharges, not related to the reimbursement levels to SNF's. And I think that again, clearly, the evidence indicates that we do not have the massive exodus to SNF's and HHA's that we were accused of in the original statement that you made in October in your October hearing.

The point is that we recognize that SNF's are being utilized to a greater degree. We know that HHA services are expanding, because we know that the industry is blossoming, that our reimbursement levels for services provided has increased. We think that is healthy, because we want people at their discharge destination to get appropriate care. But to suggest that the numbers of people that are headed in that direction as a percentage of the universe of 100 percent of Medicare discharges is dramatically up, I think it stretches the point, Mr. Chairman.

Chairman HEINZ. Well, whether the increase is 20 percent or 40 percent, the discharges to SNF's are dramatically up. If you do not think that that is a big increase, I would refer you to any number of discharge planners at hospitals around the United States. Ask them if they have got a lot more work to do with respect to planning for posthospital care for Medicare beneficiaries. We had some very good testimony from a North Carolina analyst—which I will be happy to send you—which showed that in North Carolina, at any rate, the demand for home health care and skilled nursing care was in excess of 40 percent. These are witnesses who do not work for profit making organizations and therefore should have more credibility with you.

Mr. HADDOW. Well, Mr. Chairman, I understand the point, and again, I refer you to the fact that we are well aware that home health agency reimbursement levels are up significantly, that the number of qualified home health agency providers is up significantly. That, I think, bodes well for the system, because it shows that care is being delivered, that when patients are discharged from the hospital, there is an available resource that a discharge planner can use.

I think there is a shortage in some areas, geographically, of SNF's and nursing homes, and those have to be addressed by State planners. Obviously, we are encouraging them to expand to the extent that the marketplace demands it and to provide facilities for utilization by Medicare beneficiaries who are discharged from the hospitals. We do not disagree with this, and I think we are coming very close to my original point which is that we know payment reform has to take place. We have done it in inpatient hospital settings. We are looking forward to expanding it to SNF's and home health agencies and to physicians as well, so that the payment reform will allow the entire system to become tighter and more efficient in the delivery of care. And I think that is ultimately the goal that all of us share to preserve the quality of care in that context, while we are initiating payment reform actions.

Chairman HEINZ. Senator Bingaman?

STATEMENT BY SENATOR JEFF BINGAMAN

Senator BINGAMAN. Thank you, Mr. Chairman.

Let me ask a few questions. I have looked through your testimony, and I might have missed something that you covered during your direct testimony, but let me ask you to repeat it if I did miss it.

When would you expect to have statistically valid information to really make a judgment on the effect of the DRG's on the quality of health care and whether or not there are inappropriate and premature discharges occurring; when would you expect to have enough information to really make some judgment about that?

Mr. HADDOW. Senator, we currently require the PRO's to report to us monthly on the evidence that they receive of inappropriate discharges by providers. We have analyzed as of September 1985 all of that data. Of some 8.6 million discharges that we have analyzed, we find that there are about, I believe it is 4,500 cases of suspected premature discharges, inappropriate care, and quality abuse, which is less than five one-hundredths of 1 percent of abuses.

Now, I said in my testimony that that should not be viewed as the entire universe of quality problems, but it is a good indicator that there is not a systemic problem of inappropriate discharges. They will occur. They occurred before PPS because of the imprecise art of delivery of medicine. We know that they will occur under our system. We want to accurately track both inappropriate care by providers where it is systemic, and we want to take action appropriately against those providers, whether they be hospitals or doctors.

Senator BINGAMAN. But you are satisfied that the information that you presently collect gives you a definitive conclusion that there is no significant problem in this area?

Mr. HADDOW. Well, I mentioned earlier, the GAO evaluation of our research effort to determine whether quality of care is being done appropriately really focused on posthospital stays.

We have focused on inpatient hospital stays. We have a number of studies that are ongoing right now that we expect that over the next year or two, we will be able to get outcome data that will significantly improve our ability to measure exactly what the quality outcomes are of the prospective payment system. But at the present time, we see little evidence other than anecdotal to show us that there is a systemic problem in inappropriate discharges for Medicare beneficiaries that are using prospective payment system units that are covered.

Senator BINGAMAN. I guess what I am trying to get at is, are you doing additional studies to determine if there is a problem, or have you concluded that there is no problem, and you seek additional studies to confirm your judgment?

Mr. HADDOW. We have the PRO's doing the ongoing evaluations, and we have a number of significant studies—the national quality monitoring activity study that is ongoing at the present time; we have a PRO quality assessment activity, which is a quarterly report that the PRO's provide; we have a beneficiary impact study which is ongoing. We have a hospital practice study which we expect will be annually reported every year between now and 1988; we have an ESRD study conducted by the Urban Institute, which we expect to have the results of in August 1986. We have——

Senator BINGAMAN. My question is are these studies to confirm your previous conclusion, or are you actually looking to these studies to find out whether there is a problem——

Mr. HADDOW. We are making a sincere effort to analyze what the quality impacts are of prospective payment. We do not intend to validate the present conclusion. That conclusion is drawn from existing data. We will analyze fairly and accurately and impartially any evidence resulting from this variety of studies—we are putting about $5 million into studies right now on inpatient hospital quality care delivered to Medicare beneficiaries, and we will analyze that as it becomes available.

Senator BINGAMAN. You have got $5 million going into inpatient care. What are you putting into quality of care after people are released from hospitals?

Mr. HADDOW. We are concerned about posthospital care; we will address it through the reimbursement reforms that we hope to achieve as we expand the prospective payment system to SNF's and HHA's and nursing homes, as is appropriate under Medicare.

Obviously, the focus will then shift, once we have completed or at least gotten underway the significant research effort as it relates to inpatient hospital care. We will then move to reimbursement reform and the attendant studies that will be necessary for quality review under the outpatient settings that our posthospital care needs generated.

Senator BINGAMAN. OK. But you have nothing going on now in the way of studies to determine the quality of care after——

Mr. HADDOW. No, I do not think that is accurate. Many of our studies overlap, obviously, in the outcome data. We are looking, for example, at the outcome data for patients who are discharged 30, 60, 90, or 120 days out, as to whether they suffer a fatality. We are looking at the quality of care being delivered in SNF's and HHA's to determine whether or not they are providing the proper range of services.

So I did not mean to give you the impression that we are not doing anything. Our focus has been on inpatient hospital care, with an overlap to the posthospital care setting. But we have specific studies that help us predict the quality of care in the posthospital care settings, and those are significant studies that are ongoing.

Senator BINGAMAN. You have a statement on page 18 of your testimony that, "The growth in the number of providers"—this is of home health care—"demonstrates that increased demand for these services is being met."

Do you have any other basis for that conclusion that the demand is being met?

Mr. HADDOW. Well, we are looking at not only the number of home health agencies that are becoming qualified in the system (the growth in the home health agencies has been significant as we have looked at their yearly trend), but we are also analyzing the volume of claims from those providers. And we are seeing that we are delivering postacute care setting care in the home health agency setting very effectively. So we are convinced that things are going very well. We see no need for additional legislation at this time in that area

Senator BINGAMAN. That is all I have, Mr. Chairman.

Thank you very much. I appreciate it.

Mr. HADDOW. Thank you.

Chairman HEINZ. There is a vote on. The hearing will stand in recess for approximately 5 to 10 minutes.

[Recess.]

Chairman HEINZ. The hearing will come to order.

I apologize for the delay.

Mr. Haddow, I think it is important for us to understand the kind of information that is available to you and the Congress and whether it is adequate to track the quality of care and draw valid conclusions, including suggestions for future policy. Let us conclude with a couple of brief questions. I do want to ask you about patient's rights, an issue that you brought up in your testimony.

You stated on November 4, on NBC News, and I quote, that "The bottom line is the numbers, how many cases are there of suspected premature discharge." You said that there are 4,200 out of 2.5 million discharges. That is less than two-tenths of 1 percent, and that is the whole story. You made a similar statement today. You have updated the numbers. You used 4,500 out of 8.6 million. I congratulate you—you got from 2.5 to 8.6 million in record time. But leaving that aside, does your data, which you claim is the whole story, include patients who die after discharge and who are never readmitted?

Mr. HADDOW. No, Senator, it does not.

Chairman HEINZ. Does your information include patients who are discharged to substandard nursing homes or home health care?

Mr. HADDOW. Those are handled by other review organizations——

Chairman HEINZ. I understand. But do your numbers include patients who are discharged to substandard nursing homes or inadequate home health care?

Mr. HADDOW. Yes, it covers the discharge.

Chairman HEINZ. Your numbers? Your 4,500 covers that?

Mr. HADDOW. The discharges, yes. Whether they get quality care at the nursing home——

Chairman HEINZ. You just told us a moment ago the only thing that you really were able to review were discharges where readmission occurred within 7 days.

Mr. HADDOW. Oh, I am sorry. You are talking about the outcome as to whether they stay in the nursing home and are not readmitted.

Our focus is on readmissions under the current scope of work. Our new scope of work——

Chairman HEINZ. Yes. So the answer to my question is "No."

Mr. HADDOW. Our new scope of work, which is just going out to the PRO's, includes a focus on discharges which would then cover the problem that you have identified.

Chairman HEINZ. Good. But on November 4, you were contending that you had all the information. You contend here today that you have all the information. Now——

Mr. HADDOW. Well, that 4,500——

Chairman HEINZ [continuing]. Just a minute, please—what about patients who are denied admission from nursing homes? Does the 4,500 include that?

Mr. HADDOW. The 4,500 figure includes transfers from PPS units to exempt units; it includes acute care hospital transfers and readmissions.

Chairman HEINZ. So the answer is "No," it does not include that.

Mr. HADDOW. For the PRO review, that is accurate.

Chairman HEINZ. Right. Now——

Mr. HADDOW. There are other quality review systems in place.

Chairman HEINZ. Sure. But I just want to get on the record that when you say that 4,500 or 4,200 cases represent the whole story, that is by no means the whole story. And——

Mr. HADDOW. On discharges and readmissions, it is the whole story, Mr. Chairman.

Chairman HEINZ. Well, you have just answered my questions, and the answers on the record are clear as to what the whole story is.

Mr. HADDOW. Mr. Chairman, the record ought to clearly show that there are other quality review mechanisms other than PRO's.

Chairman HEINZ. That may be. But they are not the ones that you use to evaluate quality of care——

Mr. HADDOW. That is not accurate, Senator. They do use the survey——

Chairman HEINZ. No, I have not finished my statement, either. They are not the ones you use to monitor and review quality of care on a large-scale, systemwide basis.

Mr. HADDOW. That is not accurate, Senator.

Chairman HEINZ. Then, tell me what they use.

Mr. HADDOW. They do use survey and certification data to determine whether the proper kinds of care, quality care, are being delivered to patients, beneficiaries, who utilize nursing homes and skilled nursing facilities and home health agencies.

Chairman HEINZ. And what is the proportion of SNF's surveyed? What kind of a sample is reviewed?

Mr. HADDOW. It is a significant sample. I would be glad to provide to the committee the appropriate numbers.

Chairman HEINZ. Well, is it a 1-percent sample, a 3-percent sample, a 5-percent sample?

Mr. HADDOW. It is a significant sample. I would be delighted to——

Chairman HEINZ. Well, what is it, if it is significant?

Mr. HADDOW. Well, I think——

Chairman HEINZ. You are making a big deal of it. Let us defend your position.

Mr. HADDOW. Mr. Chairman, you are making a big deal that we did not have any other reviews, and I suggest to you that they are there, they are in place, and they are working. We contract with every State in the Union to determine the ability of the patients to get good care.

All of the facilities, every single one, 100 percent of the home health care agencies, of the skilled nursing facilities, and nursing homes, are surveyed, and we make a determination whether they are capable of delivering care——

Chairman HEINZ. Now, wait just a minute. Let us not try and confuse the record. We all know what survey and certification is. It is the basis for nursing home participation in the Medicare Program; that is what that is.

Mr. HADDOW. With specific quality assurances.

Chairman HEINZ. We all know what it is. And we also know that there are 970 chronically substandard nursing homes in your database. That is something else we know.

Mr. HADDOW. We have identified——

Chairman Heinz. The mere fact that you surveyed and that you certified does not mean that patients are not discharged to substandard nursing homes. I do believe the record ought to be accurate on that. Is that not the case?

Mr. Haddow. Mr. Chairman, I think the record ought to be accurate. I am suggesting that if you identify a substandard nursing home that is providing inappropriate care to a Medicare beneficiary, it is not going to be paid under Medicare for that patient, and that will preclude it from getting the reimbursement and therefore the patients to that facility. We are looking at quality.

Chairman Heinz. Sure, and under survey and certification, you rate nursing homes. But it is also true that substandard nursing homes are allowed to continue to participate in the Medicare Program; isn't that true?

Mr. Haddow. When there is a set of deficiencies identified through the survey and certification process, we allow the nursing home to respond by giving us a plan of action to upgrade its facilities. If they fail to do so, they are disallowed from the program; we knock them out of the system——

Chairman Heinz. But they are not exactly disallowed from the program. What happens is you may sanction them in a variety of ways; you may or may not deny new admissions; you do not turn anybody out in the street. I have got nursing homes that are substandard in Pennsylvania. I know what you do.

Mr. Haddow. Mr. Chairman——

Chairman Heinz. And I am not being critical of your attempt to try and improve the quality of care in nursing homes. But not every substandard nursing home is sanctioned by a prohibition on new admissions, and that is a fact.

Mr. Haddow. If the nursing home provides a plan of action that we believe is reasonable to bring it up to standard, then no, we do not knock them out of the system; you are correct.

Chairman Heinz. Let us clarify this issue. One of the reasons that a lot of substandard nursing homes are still in the system, even though they do not always measure up to those plans for improvement that they submit to you—some of which are rather lengthy in terms of implementation—is that if HCFA really gets tough with nursing homes, they have taken the government to court. This makes it very, very tough for sanctions to be enduring and be effective. You know about all of that—we all do.

Mr. Haddow. Well, Mr Chairman, it is accurate to say that the nursing homes that are found to be in noncompliance can have an appeal process to the courts. As you know, nursing homes are primarily paid by Medicaid funds, and that is a whole different system of reimbursement. We think that Medicare beneficiaries in post hospital stays are really utilizing skilled nursing facilities in acute care settings, and we are finding that home health agencies obviously are being utilized in a significant fashion. The number of visits per patient is up to 30 in 1984 from 23 visits per patient in 1980, and we are expanding in fiscal year 1986—$2.6 billion up from $3.2 billion. So obviously, the number of visits, the number of interventions, for patients requiring that kind of service is happening. It is occurring under the system. It is not perfect, and we are struggling as you are, and we welcome the cooperative efforts to identify those areas where we can improve. And we seek to do that just as sincerely as you do.

Chairman HEINZ. Do you have any idea how many PRO's are in fact profitmaking, and how many are not-for-profit?

Mr. HADDOW. About 2 of our 54 are actual profit making entities. All of them enter into a specific contract of services, and each one would have an operating revenue surplus or deficiency, depending on its ability to execute the standards of the contract.

So if you interpret what I said as profit making versus nonprofit versus profit making in the organizational corporate sense, then I misspoke. If you understand the intent of what I said, which is the difference between operating expenses——

Chairman HEINZ. Well, the intent was to discredit the testimony of the PRO's.

Mr. HADDOW. No, no, not their testimony; only to discredit the public policy position that they may take when in fact they respond to a contractual payment, a compensation package for services delivered, at which point they would have a deficiency or a surplus, whether they are organizationally a nonprofit or a profit making entity.

Chairman HEINZ. They made public policy recommendations. However, they also attested to what they saw going on in respect to problems with quality assurance.

Let me just quote Dr. Dehn from the hearing record: "If you had to ask me what is the greatest problem in the PRO Program right now, it is the fact that it is only a snapshot in terms of the whole health care continuum. We do not know whether there are premature discharges in the PRO because we do not have the opportunity to review the care in that nursing home, nor do we have the opportunity to review ambulatory care that goes beforehand."

Mr. HADDOW. That is why the PRO scope of work is expanded, Mr. Chairman, in the coming contract cycle to allow for a far greater focus on discharges rather than on readmissions.

Chairman HEINZ. Well, maybe you will go far enough. That remains to be seen. I hope we can work with you so that we do achieve improvements in quality assurance. But I honestly have to say, I do not think you serve your case well when you insist that everything is fine now and say that is why we are improving things.

Mr. HADDOW. Mr. Chairman, I did not suggest that everything is fine now. I showed you the specific scope of work which will refine the system. We are learning from it. It was not perfect. It is not perfect today. It will not be perfect a year from now, but we are benefiting from the experience of having the system work, and we expect to refine it and continue to refine it as is necessary. That is why we are supporting your bill that allows for the PRO's to take immediate economic sanctions against providers. We think it is appropriate and needed as a real wedge against the provider that is acting inappropriately.

Chairman HEINZ. I would like to talk about beneficiary appeal rights. In your testimony you stated that several HCFA publications explain prospective payment, PRO's, and a beneficiary's appeal rights. Is one of those the Medicare Handbook?

Mr. HADDOW. Yes, it is.

Chairman HEINZ. What have you been able to do to update the text of the handbook so that it tells patients about their rights under PPS?

Mr. HADDOW. Well, Mr. Chairman, the Medicare Handbook obviously is, in my view, an inappropriate mechanism to effectively communicate patients' rights upon admission to an acute care setting. It is my belief that they should——

Chairman HEINZ. Who is supposed to read the Medicare Handbook?

Mr. HADDOW. The Medicare beneficiaries. They receive it upon eligibility. It is also available through Social Security offices, and by request from HCFA.

Chairman HEINZ. You just said it was inappropriate for them in some sense.

Mr. HADDOW. No, no, inappropriate as a way of guaranteeing that people will actually know their rights upon admission. I do not believe that the receipt of this book at the time they become eligible or request this book from HCFA is a way of guaranteeing that they will know their rights at the time of hospital admission.

Chairman HEINZ. I would agree with you, but let us see if I have got this straight. Here is a book. It is prepared for Medicare beneficiaries, and there is nothing in it about appeal rights under PPS. In the basic statement of the legal elements of Medicare, there is nothing in it that explains that the patient can in fact appeal to the Peer Review Organization.

Mr. HADDOW. Well, Mr. Chairman, that is a deficiency that will be corrected. It is my belief that the more appropriate time——

Chairman HEINZ. Well, it is a deficiency that might well be corrected. It is a fairly basic deficiency.

Mr. HADDOW. Well, Mr. Chairman, if the system works as it should, patients upon admission to an acute care facility receive a list of their rights. That specifically is addressed not only to the patients—but if the patient is incapable of understanding it, it is supposed to be delivered to a responsible person that is associated with the patient—they will then understand their rights.

Now, I was distressed——

Chairman HEINZ. Well, that is all well and good but here is my problem. You know, we have been talking with you and others about patients' rights for a number of months. There are a couple of editions of this handbook. I guess this book is published and republished every so often. I have an April 1985 version here; there is a September 1985 version which you have. Concerning the question of PRO's and Medicare beneficiaries, the subject is walked right up to on page 7: "To help Medicare decide whether inpatient hospital care is reasonable and necessary, there are peer review organizations in each State." And then it says "Medicare hospital insurance cannot pay for any inpatient hospital care that PRO's find is not medically necessary." There is a great opportunity at that point to explain that, if you as a Medicare beneficiary think you are being given the short end of the stick, you can appeal to the PRO. Just add one sentence, maybe two sentences.

Mr. HADDOW. Excellent suggestion. No question.

Chairman HEINZ. It is amazing that I have such great ideas. PPS has been with us for a couple of years. Why can't we get these things done?

Mr. HADDOW. Well, Mr. Chairman, I suppose it addresses perhaps a human frailty, and that is that in our best effort, our sincere effort, to assure that beneficiaries receive the proper information regarding their rights, we have believed that the focus of that effort should be in the acute care setting where they access that care. If we fail in that setting to provide that appeal notice, then we truly have failed the beneficiary and the system itself.

We worked with AARP in making sure that a specific pamphlet that addresses all of their rights in all of these acute care settings was made available. We are working hard to do it. You have made an excellent suggestion that I will see is incorporated into the Medicare Handbook in its next printing. But more importantly, we are focusing our effort intensely in making sure that the patients when they access care receive a notice of their appeal rights so that they can appeal if they are handled inappropriately.

Chairman HEINZ. Now, leaving aside the shortcoming on appeal rights to PRO's here, you believe, as do I, that this is a very important handbook for Medicare beneficiaries.

Mr. HADDOW. I believe it is an important handbook. I am not sure that it is read cover-to-cover by Medicare beneficiaries when they receive it.

Chairman HEINZ. Neither is the telephone book, but we would still get lost without it.

Mr. HADDOW. Excellent point.

Chairman HEINZ. Why was the number of these that were printed this year cut back from 6 to 3 million?

Mr. HADDOW. Well, it is a question of demand. We have analyzed the——

Chairman HEINZ. Who demanded that they be cut back?

Mr. HADDOW. Mr. Chairman, the demand is on the part of the beneficiaries. We allow each beneficiary to receive this upon eligibility to Medicare. We then provide——

Chairman HEINZ. We allow them?

Mr. HADDOW. Well, we provide it to them. They have access to it. And we also provide them in local Social Security offices and through HCFA upon request.

It did not seem prudent to us to have a large number of these handbooks in the new printing becoming outdated just sitting in warehouses. The storage costs alone were unjustified. We just felt that we needed to respond to the demand. If demand increases, we will expand the printing.

Chairman HEINZ. What new printing did you have in mind?

Mr. HADDOW. I am talking about the——

Chairman HEINZ. The September edition or the April edition, which are identical?

Mr. HADDOW. No, I am talking about the next edition that incorporates your excellent suggestion about PRO reviews——

Chairman HEINZ. Oh. Will that be the only difference?

Mr. HADDOW. I think we are going to analyze it more closely so we do not get caught in a position where Members of the Senate have to remind us about basic kinds of language that ought to be included in the handbook.

Chairman HEINZ. You know, here we have a new system that has been on track for a couple of years, and suddenly, it is asserted that the demand for the information in here has never been lower. You know, there are 30-some-odd million Medicare beneficiaries, and you have cut back the printing of the book to 10 percent of the number of Medicare beneficiaries. I do not know how you keep track of demand, but there certainly are all kinds of opportunities to distribute the information on the new prospective payment system. After all, it is new to a lot of Medicare beneficiaries, because in a single year, fortunately, only a small proportion of Medicare beneficiaries actually have to go to a hospital and face the new system——

Mr. HADDOW. Mr. Chairman——

Chairman HEINZ. I do not know what information you have as to demand. There is not a public service advertising campaign that says, "Ask for it." Now, how can anybody know it exists? But, let us not trivialize the hearing by getting into that kind of discussion.

Mr. HADDOW. Well, if I might respond, I can tell you how the demand is established. We have about 2 million beneficiaries every year who become eligible, and we then have an excess printing beyond that to cover additional demand. We have a lot to learn from the private sector. We get accused of waste when we have 4 million of these things sitting around in warehouses. And we are simply trying to adjust for it.

If there is an increased demand for this pamphlet, I assure you we will expand publication—we will go into a second printing of it, with the changes, that will more accurately reflect what Medicare beneficiaries need to know.

Chairman HEINZ. You stated that you recently informed the PRO's through your regional offices that PRO's must provide specific language to hospitals which the hospitals must use to inform beneficiaries of the existence of the PRO's, the fact that the PRO may review care provided, and the right of the beneficiary to appeal a decision by the PRO with which he disagrees.

Now, I have got a copy of that memorandum here; that is the October 29 memorandum—is that right?

Mr. HADDOW. I do not see it, but I think that is it, sir.

Chairman HEINZ. It is entitled, "Instructions to PRO's: Reminding You About Providing Specific Language to Hospitals for Inclusion in Their Notices to Beneficiaries Concerning Their Rights."

[The letter referred to follows:]

Department of Health and Human Services
Health Care Financing Administration, Region IV
101 Marrietta Tower
Atlanta, Georgia 30323

October 29, 1985

Atlanta Regional Medical Review Letter, number 17-85
(Of interest to Region IV Peer Review Organizations)

Subject: INSTRUCTIONS TO PROs REMINDING YOU ABOUT PROVIDING SPECIFIC LANGUAGE TO HOSPITALS FOR INCLUSION IN THEIR NOTICES TO BENEFICIARIES CONCERNING THEIR RIGHTS.

Because of recent concern expressed by Congress and by beneficiaries who have experienced significant misunderstandings, it is essential that we remind all PROs of your responsibilities to assure that beneficiaries are properly notified of their rights concerning the effect of PRO review.

As you know, section 466.72 (b) (1) of the PRO regulation on the assumption of PRO review responsibilities states that the PRO must "provide to each health care facility scheduled to come under review, a timely written notice that specifies ... the information to be furnished by the facility to each Medicare beneficiary upon admission as specified in section 466.78 (b) (3)." This latter section requires that facilities submitting Medicare claims must "inform Medicare beneficiaries at the time of admission, in writing that the care for which Medicare payment is sought will be subject to PRO review and indicate the potential outcomes of that review ... ." According to the preamble to the assumption of regulation (page 1315 of the April 17, 1985, Federal Register), it is clearly intended that these potential outcomes include a general description of the reconsideration and appeal process.

Based on these two regulation sections, PROs must provide specific language about the effects of PRO review (including appeal rights) to hospitals for inclusion in their notices to Medicare beneficiaries at the time of admission. The hospital notices, which are required and must be in writting, serve to inform beneficiaries about the extent to which Medicare payment may or may not be made for their medical services, the general process followed in making the determination of coverage, and the beneficiaries rights and responsibility. The PRO must assure that hospitals issue such notices in accordance with program regulations and guidelines.

Please send copies of the above actions to your Regional Project Officer.

Regional Adminstrator
HCFA Region IV

What it is as I read it, is in fact what it says in the title. It is a reminder. Yet, witnesses at our previous hearing said that the protections in current law are not good enough; they are not strict enough; they do not require enough. And I gather we will have some expert witnesses later today to confirm that.

Will HCFA support legislation to improve patients' rights and, equally important, to require hospitals, perhaps as a condition of participation in Medicare, to notify and inform beneficiaries of their rights?

Mr. HADDOW. Mr. Chairman, it is unnecessary. It is already a part of the contractual obligation of the PRO's, which I reminded them of, to provide——

Chairman HEINZ. Of the PRO's, but what about the hospitals?

Mr. HADDOW [continuing]. That the hospitals are required currently to provide this information to all Medicare beneficiaries, and——

Chairman HEINZ. I thought they were required to post a notice somewhere as opposed to required to give and brief and inform beneficiaries. Is that——

Mr. HADDOW. There is a notice requirement to post it in the admissions office, in each admission cubicle, so it is obvious to the Medicare beneficiary if they choose to read it. They also are required——

Chairman HEINZ. There is nothing obvious in a hospital.

Mr. HADDOW. I read it the other day when I was with my daughter—a 6-year-old, not Medicare-eligible yet—but I read it. It is there in the hospital I went to——

Chairman HEINZ. Sure, it is there, as are a lot of other things.

Mr. HADDOW. Right. Mr. Chairman, I started——

Chairman HEINZ. Just like there is an affirmative action notice that says if you are Hispanic or black or Indian-American, you have certain rights. I do not know about the hospital you go to. Maybe you have got a neat one that only posts Medicare notices of this kind. But when I have visited hospitals, there is a lot of reading material.

You are talking about somebody who is 75 years old, who is not in very good health, whose eyesight may be poor, and you are saying, "It is up there on the wall; do not worry about it."

Mr. HADDOW. The PRO's and the hospitals are required to give to each Medicare beneficiary the information about appeals on a piece of paper that they hand to them, or to a person who is responsible, if they determine that the patient himself is incapable of understanding his rights. We agree that we should expand educational opportunities for those people.

Chairman HEINZ. Is there a suggested model for such a notification?

Mr. HADDOW. It is being drafted to help the PRO's and the hospitals understand, and it will be circulated to them in the very near future. That would not—the fact that they do not have the model language would not be viewed as a reason not to do it now. But I was distressed that the PRO's—some PRO's—have not adequately enforced the hospitals contractual obligations to do so, again back to the performance standard which we are monitoring very closely, that PRO's do what we ask them to do by contract, and this happens to be one of those requirements.

Chairman HEINZ. You know, if a hospital initiates a denial, they are not required to give beneficiaries notice in writing of their appeal rights.

Mr. HADDOW. If the hospital does it without the consent of the physician, the hospital must seek the concurrence of the PRO to make that determination if the physician objects——

Chairman HEINZ. If the physician objects.

Mr. HADDOW. Well, if the physician believes that it is medically necessary or justified for that patient to be discharged, there is not an issue here, because I do not know of any system that replaces the medical judgment of the physician.

Chairman HEINZ. That is right. But you know, the problem that we are all concerned about—I hope you are concerned about it—is that there is an incentive to reduce the amount of care for individuals under the DRG system which encourages hospital administrators to make sure people are discharged just as soon as the hospital administrator thinks they should be discharged. The hospital administrator is typically not a doctor.

There are many doctors who, along with other doctors, have their names posted in hospitals because they have patients who have exceeded the DRG average length of stay. This is happening at one of my hospitals in the State of Pennsylvania. There is a message to the physician in all this, which is that the hospital administrator is a very powerful person; he is keeping track of how the doctors are handling their patients. If the doctor is not careful, he may have to go and practice medicine at some other hospital.

Now, maybe there are physicians who should not practice medicine at any hospital. On the other hand, it is also equally plausible that there is an incentive system here for physicians to give the hospital administrator more of a benefit of the doubt than under previous circumstances. And I have had physicians in my home State of Pennsylvania come up to me and say—like, Medicare beneficiaries come up and say—"There is a limited number of hospital days that Medicare will pay for and we cannot keep the patient in the hospital any more days than Medicare says."

You and I know that that is not what PPS is all about. But what I can tell you from my own personal experience is that there are an awful lot of people practicing medicine in those hospitals who do not understand it like you and I do.

Mr. HADDOW. Early on, I think that was true.

Chairman HEINZ. Early on? Just last month.

Mr. HADDOW. I think there are two specific responses, Mr. Chairman, that address that problem. The first is that a physician is certainly under no pressure to discharge a patient when it is medically unjustified to do so. If a physician pērceives pressure from the hospital administrator to do so and discharges him, Dr. Dehn himself said, that they are quilty of malpractice.

If a hospital engages in the practice—and we talked about incentives here—if it engages in the practice of premature discharge systematically, pressuring its physicians to do so, when you look at the occupancy rates of hospitals, when they are down to 60 percent nationally, and in many localities down as low as 45 percent, I cannot imagine that a hospital administration wants to get the reputation of premature discharges when its occupancy rates are so low, anyway.

I believe that the competitive system gives us an added buffer of safety; it is an incentive that is more powerful than any regulatory framework that we can offer, and I think the behavior of hospital administrators has certainly proven that they are responsive to incentives that work effectively.

But most important——

Chairman HEINZ. It is interesting to me that what I have just described to you is a phenomenon that takes place where there is not much competition. I do not get those complaints in the big cities where there are plenty of hospitals. I get them in the other 60 of my 67 counties where there are not lots of hospitals competing with each other. In those 60 of my 67 counties in the State of Pennsylvania, we do not have the kind of intense competition that you will find in Philadelphia and Allegheny County and Erie County and Dauphin County and Lackawanna County. The problem is that in fact there are a lot of hospitals out there on their own. They are called rural hospitals.

Mr. HADDOW. I understand, Mr. Chairman.

Chairman HEINZ. I have the largest rural population of any State in the Nation, 2.5 million Pennsylvanians. That is a lot.

Mr. HADDOW. Well, in response to the specific problem that you indicated about posting of patterns of practice of physicians in a hospital setting, certainly, the focus of the prospective payment system was to reduce unnecessary hospitalization and reduce unnecessary testing, unnecessary surgical procedures. And what we found prior to PPS was a lot of convenience medicine being practiced that said to a patient, "If you want to stay in the hospital a little longer, you can."

This obviously impacts on that kind of physician, and the physician would justifiably say, I suppose, in terms of human instinct, that, "The Federal Government is making me discharge you." We take that rap all the time, and that builds an impression of the system that is inaccurate, but yet feeds this idea that the DRG limits are up.

Most importantly, I think a hospital administrator has the right to look at a doctor who, over a period of many patients, does not perform very well when it comes to that convenience medicine, rather than the actual medically justifiably practice that they engage in with discharges.

Chairman HEINZ. No, that is not at issue.

Mr. HADDOW. I just do not see that being a major problem.

Chairman HEINZ. That is not the issue. The issue is whether or not, when there are hospital-initiated denials, there is any protection to the patient, and whether given the incentives under PPS which, you know, if you are a hospital and you are operating at 50- to 60-percent capacity, it is even more important to be able to make money on the patients that you do get, the incentives can get pretty strong. And at this point, hospital-initiated denials do not require that the patients be given their appeals rights in writing. That is true, is it not?

Mr. HADDOW. Mr. Chairman, no, it is not.

Chairman HEINZ. No?

Mr. HADDOW. If a hospital seeks to release a patient without the physician's consent—which is the case you are talking about here—they are required to obtain PRO concurrence and to give notice to the patient in writing.

Chairman HEINZ. I am talking about with the physician's consent.

Mr. HADDOW. There is not an issue here. If a physician consents to a discharge, it is not the hospital that discharges them; it is the physician doing so. And there are the malpractice claims available to a patient. I do not know that what you are suggesting here is that we somehow look over the shoulder of an attending physician and that there be some sort of review. I do not think that is what you are suggesting.

Chairman HEINZ. What is wrong with requiring a hospital that initiates the discharge to inform the patient of his rights?

Mr. HADDOW. Let me clearly state again, Mr. Chairman, that I think what your staff has indicated to you is inaccurate. When a hospital initiates a discharge, there is a requirement that a notice must be submitted in writing to the patient, and that patient then has specific appeal rights. If a doctor initiates a discharge and determines that it is medically justified, the patient cannot appeal to the PRO.

Chairman HEINZ. But he does not have to be informed of it; they are not required to be informed of it.

Mr. HADDOW. Well, no, but they have, at the time of admission, information on appeal rights given to them by the hospital. If they disagree with the hospital's determination, they can appeal to the PRO.

Chairman HEINZ. I understand. It is just a question of whether they are required to be notified. And I do not understand why you do not want to require the notification of those patients in each and every instance.

Mr. HADDOW. When a physician makes a determination that it is medically justified to discharge a patient it is only important in the case where the patient objects to it, in which case they have the opportunity to say to their physician, "I do not feel like I should go home right now." And the physician—I do not understand what exactly we are looking for in terms of the written notice. The physician comes in and says, "I am signing a discharge order, and you are going home." And the patient can say to his doctor at the bedside visit——

Chairman HEINZ. Wouldn't it be a lot better that when the patient is admitted, there is a requirement that the hospital notify him of his rights, make sure he understands his rights——

Mr. HADDOW. It would not be better; it would be better if it worked. We currently have that in place, and we are requiring that the PRO's meet their contractual obligations to monitor the hospitals——

Chairman HEINZ. You are requiring that the PRO's do it; you are not requiring that the hospitals do it.

Mr. HADDOW. The hospitals have to do it and the PRO's are to ensure they do. Senator, I just say that you are misinformed about the present system. We require that information about appeal rights be given to the Medicare beneficiary upon admission. It is a better system. It is what is currently in place. I do not see how strengthening that will make it any more effective than what we are doing right now.

We require the hospitals to do it. We are giving them the language through the PRO's to do it. We want beneficiaries to be educated about what their specific appeal rights are. We support you in that role. We do not think there is a necessity for any onerous legislation to do it.

Chairman HEINZ. We seem to be having a little trouble nailing this down. If a hospital is not going to charge the Medicare beneficiary—if it is not going to send the beneficiary a bill—but is going to discharge them, is the hospital required to notify the patient of his rights?

Mr. HADDOW. Assuming they bill Medicare rather than the patient?

Chairman HEINZ. Yes.

Mr. HADDOW. Yes, they are required, if the hospital initiates the discharge they are required to notify him 2 days in advance of the discharge.

Chairman HEINZ. And they are required to notify the patient of his appeal rights?

Mr. HADDOW. Absolutely—giving the name of the PRO and the phone number he can call.

Chairman HEINZ. And so that is true whether or not the hospital is going to charge the patient?

Mr. HADDOW. That is correct. Any hospital-initiated discharge requires a written notice 2 days in advance of the discharge to the patient, and the patient then has the option of staying in the hospital, and if it is determined by the PRO once they investigate it that it was a justified release the patient is liable for that extra day.

Chairman HEINZ. I would suggest to you that there are a lot of hospitals out there who do not know that.

Mr. HADDOW. There may be some, Mr. Chairman. We are working to educate them very, very quickly; hence, the evidence that we are informing the PRO's, who are required through the regional offices to monitor the hospitals. We are strengthening that system.

Chairman HEINZ. It needs a lot of it.

I thank you for appearing here. I must say that I really worry about HCFA's insistence that they really understand what is going on out there, because one thing I have learned in public policy over the last 10 or 12 years is that when we do something in Washington, there is no better than a 50-50 chance that we are going to know exactly what is happening out there, that it is working out as we intended.

We have this little piece of paper called a law that we write, and everything is worked out on that piece of paper, and of course, the world is so much more complicated. By the time you actually implement a program, it just turns out that it does not go quite as smoothly.

Maybe this hearing has been useful to you—I hope it has—in illustrating that there is a wealth of information suggesting that there is an awful lot that neither you nor we know, and that the longer we postpone getting the very best possible information, that we are going to be risking people's health and welfare.

I do not want to believe that the Health Care Financing Administration is willing to take those kinds of risks, and I am not going to draw the conclusion today that you want to take those kinds of risks. But I do think you are trying to defend a system that has many incentives that could create serious problems for beneficiaries. My most charitable interpretation is that I do not think you are fully aware of how serious those problems indeed may be out there. Most importantly, you do not have the information to tell you of what is happening. Maybe you want the information. Maybe you are going to be able to get the information. But the fact is that you have a very tiny piece of the story to assert that for the 8.6 million beneficiaries discharged from hospitals, (or 2.5 million a couple of weeks ago), that there are no quality of care concerns. The data you have because of the way the PRO's report, are referring mainly to cost reviews, to cost containment reviews, not to quality of care reviews. The PRO's themselves are saying, "We do not have the information that we need to assess what is happening on discharge." I thus worry that you may conclude that you really have all the information when in fact you have very little of it.

Mr. HADDOW. Well, Mr. Chairman, I hope that it has been helpful to the committee as well to have a more complete record of what our attempts have been. Hopefully, I have conveyed to you our sincere intent to work cooperatively with you to refine the system, and if you would allow me, I would perhaps like to make a response to a question you posed to an earlier witness, regarding whether they would expect and encourage their parents if they were alive and Medicare-eligible to access the PPS system as it currently is in place. I have a mother who is almost Medicare-eligible, and I would have no problems with her in a complex situation entering and receiving care under the Medicare prospective payment system.

Lest someone say that I do not care much about my mother, might I expand that to say that if I suffered from a comparable situation, I would be perfectly willing to enter the prospective payment system hospital——

Chairman HEINZ. We care more about our mothers than ourselves.

Mr. HADDOW. Well, just know that I would be willing to enter it and have full confidence that the care that I was delivered would be the highest quality possible.

Chairman HEINZ. I am more interested in how you feel about your mother. After some of the statements you have made here today, I do not know what sense of self-preservation you have. [Laughter.]

Mr. HADDOW. Well, being a Pittsburgher by birth and origin, and understanding what "street fighting" is, as you do, Senator, I know that you understand that my mother was going to get the best care. I would be very concerned about it, and under the prospective payment system she would get that, I am convinced, and the highest quality.

Chairman HEINZ. In Pittsburgh, she would get good quality care.

Mr. HADDOW. And she would virtually anyplace in the country.

Chairman HEINZ. It is America's most livable city.

Mr. HADDOW. That is right.

Thank you, Mr. Chairman.

Chairman HEINZ. Senator Dodd, do you have any questions for this witness?

STATEMENT BY SENATOR CHRISTOPHER J. DODD

Senator DODD. Yes. Do not run off.

First of all, let me apologize to you and to the chairman. We have had one of those days where there are four or five committee meetings simultaneously this morning and unfortunately everyone suffers as a result of that. But I appreciate your being here, as well as the other witnesses.

I gather that this might go on for the next couple of days, given the progress we are making.

I do have an opening statement, Mr. Chairman, which I would ask unanimous consent be made a part of the record.

Chairman HEINZ. Without objection, so ordered.

[The prepared statement of Senator Dodd follows:]

PREPARED STATEMENT OF SENATOR CHRISTOPHER J. DODD

Mr. Chairman, I am pleased to attend this third hearing in a series the Senate Special Committee on Aging is conducting on quality of care under the present Medicare system. Few issues are more important than the quality of health care available for older Americans.

The first two hearings laid out the basic problems now surfacing with quality of care for older Americans under our Medicare system. The committee heard firsthand of cases of serious ill senior citizens being discharged from hospitals before their medical condition is stable. We heard other reports of patients not being apprised of their rights to appeal discharge decisions. And, this committee heard yet other cases described in which hospitals have denied admission to patients suffering from severe conditions because they will not be adequately reimbursed under Medicare for caring for such patients.

This morning we examine the Government's role in ensuring quality of care for older Americans under the Medicare system. With the enactment of the prospective payment system in 1983, Congress changed fundamentally Medicare reimbursement, converting it from a cost-based, retrospective system to one based on fixed payments. Yet congressional concern with containing health care costs under the Medicare system 2 years ago was clearly premised on a mandate to maintain the quality of medical care provided to Medicare beneficiaries. Thus it is with great interest that I look forward to the testimony of this morning witnesses. I expect that they will have valuable recommendations on ways to curb inflation and unnecessary spending under the Medicare system without sacrificing the quality of care provided to olders Americans.

Senator DODD. I gather you have been under a rather lengthy set of questions from the chairman of this committee. Unfortunately, we did not get a lot of the testimony until late yesterday, which was a holiday, so it made it somewhat difficult for some of us to get prepared for this.

But let me just ask you two quick questions, if I can, and then we will let you go and move on to the other witnesses.

You talked about other quality of care review mechanisms besides the peer review organizations. I wonder if you might go into some description of what those other mechanisms might be, and how they would work I would also tell you that if you are not prepared to go into great length on that at this particular juncture, because we do have other witnesses, that maybe you might submit that to the Committee. But you made reference, I gather, earlier to other mechanisms.

Mr. HADDOW. Senator, I would be delighted to give you a detailed account of the interrelationships of all of the quality mechanisms that are in place. But briefly, they include a survey and certification process that each provider of care must submit to and have recurring surveys to determine their continued eligibility for providing Medicare services.

We also require that conditions of participation be met by providing institutions which guarantee a level of quality care and the nature of the providers of care and medical professionals and the standards of conduct they are required to implement in their institution.

We have the PRO's, which evaluate the inpatient hospital care. We also have the fiscal intermediaries and the carriers evaluate on generic screens a variety of the kinds of care that are prescribed for Medicare and Medicaid beneficiaries.

So I think that we have a system in place which is supplemented, I think significantly, by a more competitive marketplace, enhanced by prospective payment, in revolutionizing the reimbursement mechanism. We look forward to expanding that to post-hospital settings—skilled nursing facilities and home health agencies and nursing homes—so as to complete that incentive that would be part of the competitive marketplace and would guarantee quality.

Senator DODD. Well, you anticipated my next question, because I wonder how much checking there really is going on with discharges, particularly in the nursing home arena, to follow up. It seems to me you have got to complete that particular part of this process or we are not getting the kind of information we ought to be getting.

At this point, there really is very little of that followup; is that not true?

Mr. HADDOW. We expect, in focusing now on reimbursement reform, to expand to posthospital care settings, that we would focus on quality issues as they relate to provision of services under skilled nursing facilities or home health agencies.

When they are cost reimbursed, as the acute care hospital settings were prior to PPS, the feeling was that there was actually an overutilization, an overprescription of care for patients. We have seen that evidenced in the acute care hospital setting and dramatic changes in behavior evidenced under PPS.

We think similar kinds of efficiencies and quality behavior patterns can be introduced into the posthospital care settings.

Senator DODD. But I would also assume that in the process, you will be focusing on premature discharges. It has been a major concern, and in fact the subject of hearings of this committee not that long ago. It would seem to me, in addition to the information you just talked about, that the peer review organizations could be examining the major questions arising from premature discharges.

Mr. HADDOW. There is no question, Senator, that when we first designed the first series of contracts with the specified requirements of the contracts, we were focusing on readmissions as our quality indicator. The new scope of work, which is given to the PRO's in the next cycle of contracts which is starting shortly will allow for a specific focus on premature discharges. We will emphasize quality, because we have learned in the first year of implementation that that is a specific need that we have, to monitor quality outcomes from discharges.

Senator DODD. I wonder if you might also submit to the committee a report outlining how much credence HCFA places on the various other quality-of-care mechanisms that you talked about, in addition to the peer review organizations. I think that would be helpful as well and I would ask you to submit that report in writing.

Mr. HADDOW. I would be delighted to submit that in writing.

Senator DODD. Thank you. I appreciate your staying a little longer and apologize for holding you.

Thank you.

Mr. HADDOW. No problem. Thank you very much.

[Subsequent to the hearing, the following was submitted for the record:]

In addition to PRO's, HCFA uses two major quality assurance mechanisms: medical review and survey and certification. Let me briefly describe each:

Medical review is conducted by fiscal intermediaries and carriers. Under this process, claims are screened against certain criteria. Those claims that do not pass the criteria are subjected to intensive medical review by a qualified health professional using patient-specific medical information (e.g., medical records). Based upon the results of the review the case is either approved and payment made or the claim is denied and corrective action initiated.

The survey and certification process is conducted by State health departments. They conduct inspections of all health care facilities participating in Medicare and Medicaid. Based upon these inspections, the facilities are either approved for participation or disapproved; that is, if they were to apply to participate they would be denied and if they already participate, they would be terminated.

I believe these systems are highly reliable in detecting problems with quality. Certainly they, like most processes, can be improved, and we are constantly evaluating them both through our own internal evaluation systems as well as in cooperation with consumer and industry groups.

Chairman HEINZ. Would our next panel of witnesses please come forward—Dr. Leon Malmud, of Temple University Hospital in Philadelphia; Dr. Susan Horn, of Johns Hopkins in Baltimore; Vita Ostrander, president of the ARRP; Judy Waxman, of the National Health Law Program; Dr. Catherine Hawes, of the Research Triangle Institute in Triangle Park, NC, and Dr. Gerald Eggert, executive director of the Monroe County Long-Term Care Program in Rochester, NY.

Ladies and gentlemen, thank you very much for your patience. I apologize that the hearing has run longer; that is partly the chairman's fault.

I would ask each of you to try to keep your statements as concise as possible so that Senator Dodd, myself, and others will have an opportunity to question you before we have to leave for another vote.

Let me ask Dr. Malmud, who is a practicing physician in the Philadelphia area at Temple University, and who is very knowledgeable on a variety of issues, to be our first witness.

Dr. Malmud, welcome, and thank you.

STATEMENT OF LEON S. MALMUD, M.D., ASSOCIATE DEAN FOR CLINICAL AFFAIRS, TEMPLE UNIVERSITY HOSPITAL, PHILADELPHIA, PA

Dr. MALMUD. Thank you, Mr. Chairman.

I am Leon Malmud, professor of medicine and professor and chairman of the Department of Diagnostic Imaging at Temple University Hospital and School of Medicine, where I also serve as associate dean for clinical affairs.

Both as a professional in the field and as one of your constituents, I would like to thank you for the opportunity to present this testimony.

Temple University Hospital is a 482-bed, nonprofit institution and is the primary teaching hospital for our school of medicine. It is located in one of the most economically depressed areas in Philadelphia, with fully 70 percent of our patients covered either by the Medicare or Medicaid Programs.

We are the largest provider of indigent care in the Commonwealth of Pennsylvania. Temple has the fourth-highest level of Medicaid patients of all university-owned hospitals in the entire Nation. Last year alone, we provided approximately $10 million in underreimbursed or totally unreimbursed care, representing nearly 10 percent of our hospital's annual budget.

I have been asked to respond to the issue of whether or not the DRG classification system allows for appropriate reimbursement for the care of Medicare beneficiaries. My answer is a conditional yes.

Certainly, the DRG system, which is case-based reimbursement system, has already proven to be superior to the old cost-based system in decelerating the rate of increases of hospital care costs.

As to the policy initiatives needed to strengthen the DRG patient classification system, I would like to offer the following suggestions. First, I would recommend an adjustment for severity of illness under each DRG. This would be a graded measure according to the intensity or the stage of the primary disease process. A coding system for such changes already exists for cardiac and rheumatologic disorders and should not be difficult to compile for other disease systems.

Hospitals such as Temple usually treat patients only with the more severe forms of disease. Yet the DRG reimbursement system reimburses hospitals at about the same rate, regardless of the patients they treat. And some hospitals market particularly the patients with lesser degrees of illness. I know the next witness will be addressing this issue in greater detail, so I will not take your time with it now.

The second recommendation would be for an adjustment for complexity of illness—the first for severity, the second for complexity. This would account for such factors as coexisting illness, age, mental status, and nutritional state. For example, an 80-year-old patient with congestive heart failure and chronic renal disease and diabetes will have a much stormier and prolonged hospital course than a patient age 70, also covered by Medicare, admitted with congestive heart failure alone.

In treating the congestive heart failure, coexisting renal disease often temporarily worsens. Diabetes, which may have been controlled prior to the hospitalization, may also decompensate during the treatment for congestive heart failure, as might the electrolyte balance in the blood. This is not accounted for adequately in the present DRG system.

In addition to those two adjustments for severity of illness and complexity of illness, a third improvement to the present DRG system is one that would address the social and economic status of the patient. Economically disadvantaged patients often come to hospitals much later in their illnesses than do more affluent patients. Factors responsible for this include the unavailability of a primary physician and lack of intact family support systems to encourage the elderly to seek medical help early.

In addition, the elderly often arrive with histories of inability to pay for prescribed medications and are in nutritionally deficient states.

For example, at Temple, nearly 65 percent of all outpatients are recognized as having nutritional deficiencies on admission. Because of this, we spend nearly half a million dollars a year on hyperalimentation alone.

The DRG's do not adequately reflect these costs, even given the added support for indirect medical education, and it should be noted that these educational supports are currently decreasing.

We also need to better address the issue of improved posthospitalization care—a need which results in part from the shorter hospitals days mandated by the DRG system itself. Many patients treated at Temple are not ready to be safely discharged from inpatient care within the time frame established. They often live alone and may not be ready or able to climb several flights of stairs to get to their rented rooms, which are often inadequately heated and not in reach of adequate bathroom facilities.

Often, we are unable to find skilled nursing care facilities or continuing care facilities willing to accept these patients, although the physicians feel that the patients are prepared to leave the hospital and that they do not require acute care any longer.

Knowing these facts, the staff at Temple often makes the conscious decision to keep the patient beyond the point where the DRG offers economic advantages.

In summary, we at Temple University Hospital have already responded in a positive way to the DRG system in a medically responsible and caring way. We have reduced our length of stay by almost 17 percent, from 9.3 days to 7.7 days. We held our cost increases to only 4.5 percent last year. And within the past 3 years, we have kept our rate of increase 11 percent below the other Philadelphia teaching hospitals—there are four others.

We bear a disproportionate share of indigent elderly, plus distant referred elderly patients with complex problems, specifically referred to us because of the complexity of their problems.

More affluent and profit-oriented hospitals are marketing heavily to increase their share of relatively healthy younger patients, whose DRG classifications are seen to be profitable, thus drawing off from us those types of patients whose shorter stays would offset the losses that we bear in treating the elderly and the more severely ill.

We are committed to delivering high-quality health care, and we need help in strengthening the DRG system by factoring in compensation for care of the elderly with multiple medical, economic and social problems.

Mr. Chairman, I would be more than happy to answer any questions you might have.

Chairman HEINZ. Thank you very much, Dr. Malmud.

[The prepared statement of Dr. Malmud follows:]

PREPARED STATEMENT OF LEON S. MALMUD, M.D.

Mr. Chairman, I am Leon S. Malmud, M.D., Professor of Medicine and Professor and Chairman of the Department of Diagnostic Imaging at Temple University Hospital and School of Medicine, where I also serve as Associate Dean for Clinical Affairs. I'd like to thank you for the opportunity to present this statement, not only as a professional in the field, but also as one of your constituents. Temple University Hospital is a 482 bed, non-profit institution and is the primary teaching hospital for our School of Medicine. It is located in one of the most economically depressed areas in Philadelphia. Fully seventy percent of our in-patients are covered by either the Medicare or Medicaid programs.

Temple University Hospital has a dual mission. First, it is firmly committed to serving the indigent population of our community. Secondly, it maintains a leadership role amongst teaching hospitals by its commitment to the advancement of medicine via research and the clinical application of the newest technology in both diagnosis and treatment. Temple is the largest provider of indigent care in the Commonwealth of Pennsylvania and has the fouth highest level of Medicaid patients of all University-owned teaching hospitals in the entire nation. We provide approximately ten million dollars in under-reimbursed or unreimbursed care, representing nearly ten percent of our annual budget.

I have been asked to respond to the issue of whether or not the DRG classification system allows for appropriate reimbursement for the care of Medicare beneficiaries. My answer woud be a "conditional" yes. Certainly the DRG system, which is a case-based reimbursement system has already proven to be a more cost effective method than the old cost-based system. However, there are at least 4 improvements that I perceive could be made to the present system.

The first relates to severity of illness. By severity I mean the intensity of the illness. For example, DRG #88 Chronic Obstructive Pulmonary Disease, may be mild or severe but not severe enough to be classified as DRG #87, Respiratory Failure. A patient with a milder form of the disease usually requires far less intensive medical nursing a technological support than another patient at the other end of the spectrum. Hospitals such as mine usually treat only the severe form of a disease. Yet, the DRG reimbursement rate for our hospital is about the same as for those hospitals who primarily see patients with a milder form of the disease.

Secondly, the complexity of illness is not adequately addressed by the existing system. By complexity I mean concomitant illnesses. For example, a patient with congestive heart failure and co-existing chronic renal disease, high blood pressure and diabetes, will have a much stormier hospital course than another patient admitted with congestive heart failure only. In treating a patient with congestive heart failure and renal disease, the kidney function may worsen. Similarly, diabetes which may have been controlled prior to the episode of congestive heart failure, may become difficult to control, as might electrolyte balance in the blood. While it is true that the DRG system accounts for certain outliers, what the system does not account for is hospitals which bear a disproportionate number of such patients, such as mine. As you know, this has resulted from the method by which data was collected.

When the DRG system was established the data was collected by taking the ICD-9 codes, that is, the International Classification of Diseases, 9th Edition, and then randomly sampling social security patient recipients whose numbers ended in a certain digit. This resulted in national averages for all DRG's. Thus, while hospitals with high intensity cases such as our own, are clearly included in these figures, we are in fact under-reimbursed, as we have a higher than average percentage of poor elderly patients with other problems including multiple diseases, poor nutritional status, unavailability of prescription drugs due to insufficient funds, and patients who frequently lack a single primary care physician to direct their overall care.

The third issue that the present DRG system does not adequately address relates to the socio-economic status of the patient. Economically disadvantaged patients often come to hospitals much later in their illnesses than more affluent patients. There are many factors responsible for this such as, unavailablility of a primary care physician, and lack of family support systems to encourage them to seek medical help. In addition they arrive with stories of inability to pay for prescibed medication and often are in nutritionally deficient states. For example, at Temple University Hospital nearly 65 percent of our patients are recognized as having nutritional deficiencies on admission. Because of this we spend nearly half a million dollars a year on hyperalimentation support alone. The DRG's do ot reflect these added costs, even given the added support for indirect medical education. It should be noted that these educational supports are currently decreasing.

The fourth improvement needed in the DRG's concerns the increased need for improved quality post-hospitalization care, a need which results in part from the shorter hospital stays mandated by the DRGs. Many patients treated at my hospital are not ready to be safety discharged from in-patient care within the time frame established. This is because of their greater severity and complexity of illness, and socioeconomic status.

They often live alone, and may not even be ready or able to climb the several flights of stairs to get to their rented rooms which are often inadequately heated and not in reach of bathroom facilities. Knowing these facts, the staff at Temple often makes the conscious decision to keep the patients in the hospital behind the point where the DRG offers economic advantages. This is one of the contributing factors to Temple's ten million dollar loss in unreimbursed care last year.

A related issue to this one is the fact that Medicare guidelines for admission to Hospital-based skilled care facilities such as Willowcrest-Bamberger, an outstanding such facility in Philadelphia, are so strict, that they exclude most patients, who any layman would agree, require the type of care which they best deliver.

Lest you think that my above points are only statistical abstractions, let me relate to you the experience of an 80 year old man with whom I am personally acquainted. He was referred from another hospital to Temple for a neurosurgical procedure. Following the surgery, the patient, who had known prostrate problems prior to surgery, developed urinary retention, that is, he was not able to spontaneously void urine. A second surgery was required for that problem and because of the duration of the patient's urinary tract problem, the bladder had lost its tone, and a catheter was required post-operatively. In addition, prior to hospitalization, the patient's diabetes was managed with oral agents. While in the hospital, the patients diabetes became more severe, and it became necessary to start him on insulin for the first time. Lastly, during this prolonged hospitalization, the patient had a slight stroke primarily involving his facial muscles. On discharge, he was able to walk only with assistance and a walker. The Medicare reimbursement standards for transfer to Willowcrest-Bamberger are so strict, that this patient was initially denied transfer.

The man has worked all of his life, and in fact continued part-time employment up to the time of hospitalization in order to supplement his social security income. Since the death of his wife, he has lived alone in a second floor apartment. At the time of discharge from the hospital he was unable to walk up the stairs to his apartment, and had he been able to get there, he would then have been unable to bathe himself, prepare his meals, correctly take his insulin, care for his catheter or leave the apartment in order to go shopping. It was only after one full week of intense activity by his primary care physician and the surgical team and the Social Service Department at Temple, that the rules finally were interpreted so as to permit his admission to the hospital-based skilled care facility. That he benefited from that after care is unquestionable, as he is now ambulatory, able to drive, and fully able to care for himself in an apartment complex for the elderly to which he has subsequently moved. Yet, present standards are so strict for transfer to such facilities, that the one to which he was admitted has had a high vacancy rate for the past number of years, due to Medicare's standards for reimbursement.

What policy initiatives are needed to strengthen the DRG patient classification system?

First, I would recommend a severity of illness adjustment under each DRG. This would be a measure that is graded according to the intensity or stage of the primary disease process.

Second, I would recommend a complexity of illness adjustment. This would be based on factors such as, concomitant illness, age, mental status, nutritional state and socio-economic factors.

Third, I would recommend a provision for greater use of short term skilled-care facilities, especially for those patients who are disadvantaged—economically or socially. Willowcrest, for example, helps return people to independent living in the community, people who would otherwise languish permanently in nursing homes.

In summary, Temple University Hospital has already responded to the DRG system by reducing our length of stay by almost seventeen percent from 9.3 days to 7.7 days. We held our cost increase to only 4.5 percent last year, and within the past three years have kept our rate of increase 11 percent lower than the other Philadelphia teaching hospitals. We bear a disproportionate share of indigent elderly patients, plus referred patients with complex problems. Last year we bore a ten million dollar loss in uncompensated care, some of it under-reimbursed, some of it totally unreimbursed. In addition, many suburban affluent hospitals are marketing heavily to increase their share of relatively healthy, younger patients, whose DRG classifications are profitable, thus drawing off from us those types of patients whose shorter stays would offset the losses that we bear in treating older and sicker individuals. If we are to continue to deliver high quality health care, we need a DRG system which is strengthened by factoring in compensation for care of the elderly with multiple medical, economic and social problems.

Mr. Chairman, I'd be more than happy to answer any questions you might have.

Chairman HEINZ. Dr. Horn?

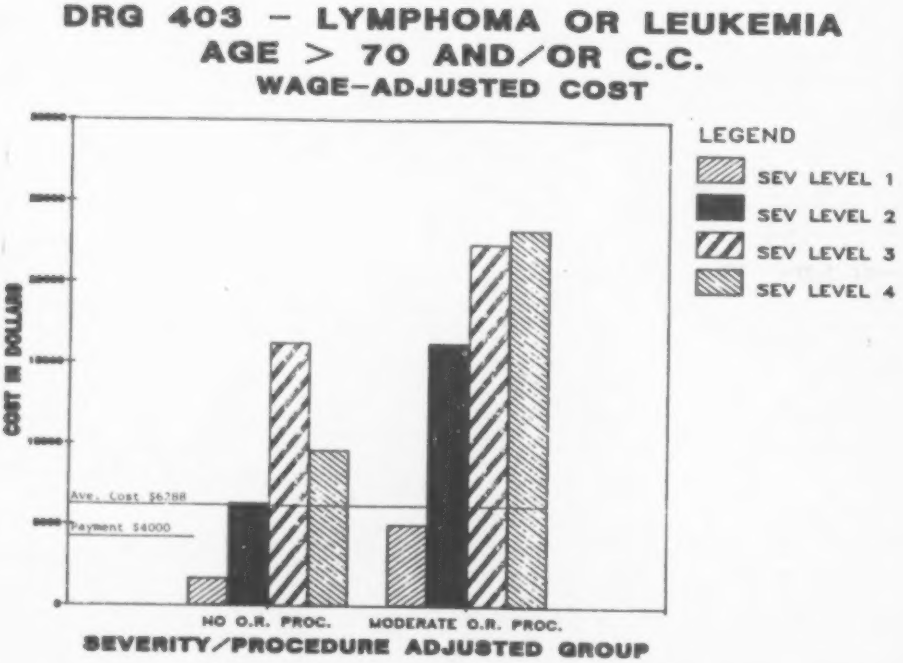
STATEMENT OF SUSAN D. HORN, PH.D., THE JOHNS HOPKINS UNIVERSITY MEDICAL INSTITUTIONS, BALTIMORE, MD

Dr. HORN. The introduction of prospective payment of hospitals based on DRG classification has been a positive initial step toward cost containment in the health care industry. However, experience suggests there are important ways the system can be improved.

In a prospective payment system, it is critical that patients classified together require similar quantities of resources. Large differences in resource consumption within groups lead to unintended financial risk for hospitals, undesirable incentives for poor quality of care, such as premature discharge, and improper profit through opportunistic patient selection.

Research shows that most DRG's group together patients who require widely different resource use. This is reflected by the fact that DRG's explain only about 30 percent of the differences in hospital resource use per case. Further research confirms the clinical intuition that differences in severity of illness explain a large part of the remaining differences.

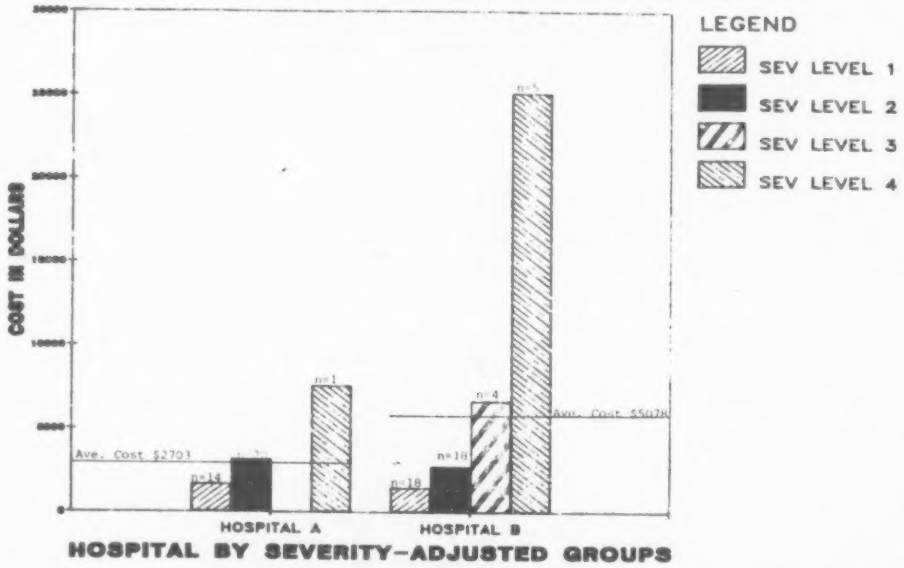
Figure 1



For example, in Figure 1, we demonstrate the average cost per case for patients in a cancer DRG-403. We see variability both by severity of illness level, as well as whether or not the patient has had an operating room procedure. Neither factor is recognized within this DRG. Thus, hospitals that treat proportionately greater numbers of more severely ill patients can be substantially underpaid. A hospital receives about $4,000 for each patient in DRG-403, but this hospital's average cost per case in DRG-403 was over $6,000 because of the severity distribution of the patients.

Figure 2

DRG 88
CHRONIC OBSTRUCTIVE PULMONARY DISEASE
WAGE-ADJUSTED COST



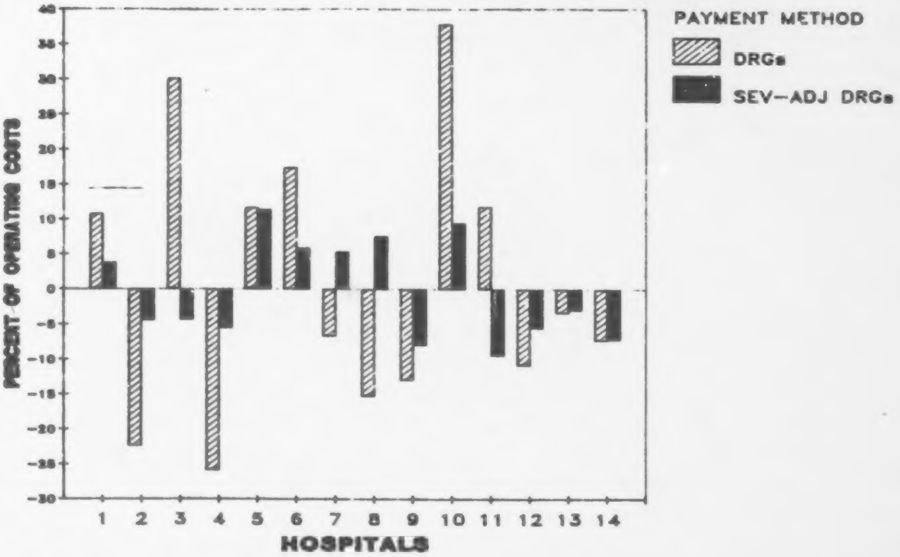
Another common disease among the elderly is chronic obstructive pulmonary disease, DRG-88, represented in figure 2. These data are from two hospitals—hospital A, a university teaching hospital with an average cost per case of $2,700, and hospital B, a community hospital with an average cost per case of more than $5,000. The community hospital's average cost is almost twice that of the university teaching hospital, because the patients in the community hospital are more severely ill. There are nine patients in severity levels 3 and 4 in the sample from hospital B, while there is only one such patient in the sample from hospital A. Thus, adverse impact of severity of illness differences in DRG's is not restricted to university teaching hospitals. The type of hospital is not the issue, but rather, the type of patient.

The current DRG prospective payment system, even with multiple adjustments for teaching status, urban and rural status, proportion of indigent patients, and tertiary referral center designation, all attempted surrogates for severity, does not adequately recognize this.

These are not atypical examples A recent study funded by HCFA revealed that 94 percent of the DRG's contained wide variation in severity. The result: When hospital payments are based on DRG's alone, some hospitals will be greatly overpaid, and other hospitals will be greatly underpaid.

Figure 3

IMPACT ON PROSPECTIVE PAYMENT
OVERPAYMENTS AND UNDERPAYMENTS AS A PERCENT OF TOTAL OPERATING COSTS



This is demonstrated in figure 3, where we have simulated paying each of 14 studied hospitals on the basis of an unadjusted DRG system, in red, and on the basis of a severity-adjusted DRG system, in blue. Both payment mechanisms are budget-neutral. That is, the total amount of money paid out to the 14 hospitals is the same under both systems.

However, the unadjusted DRG's result in much greater overpayments and underpayments than the severity-adjusted DRG's. The severity-adjusted system is fairer, relies less on internal cross-subsidization, and sends rational market signals to the hospitals.

Adjusting DRG's for severity of illness would diminish or eliminate some disincentives in the current prospective payment system—in particular, hospitals treating a less severely ill caseload would not be unduly rewarded. Overpayment of less severely ill cases, using the present DRG system, provides no incentive for efficient production of services.

Hospitals treating a more severely ill caseload would not be unduly penalized. More severely ill patients have justifiably higher costs, which must be paid for somehow if these hospitals are not to be bankrupted and our national treatment system destroyed.

There would be no incentive to overadmit less severely ill patients. The level of payment for such patients would be reduced.

Incentives for premature discharge or "dumping" of sicker patients would be reduced if the justifiable extra costs of caring for such patients were appropriately paid for.

There would be improved control of resource use, because of more accurate matching of resource requirements to each patient's burden of illness. One hospital now using severity of illness data for internal management purposes has estimated about 30 percent of variable costs could be saved by evaluating resource use by severitv level.

Finally, atypically high patterns of resource use at the hospital level or the physician level can be more easily identified and corrected when severity grouping is used.

In summary, prospective payment has in principle many excellent incentives to control health care costs, as you have discussed before. However, steps to control costs should be equitable and provide incentives for high-quality care.

A patient classification system used for prospective payment should be fair and accurately describe a patient's resource needs. It is clear that DRG's alone are too coarse for this purpose, and research has shown that the severity surrogates now used do not adequately address the differences.

If DRG's were modified by a direct severity of illness adjustment, much of the present inequity in payment could be avoided; all hospitals would have incentives to deliver efficient and high-quality care no matter the age or wealth of the patient, and government expenditures for hospitalization could be more effectively restrained.

Thank you, Mr. Chairman.

Senator DODD. Mr. Chairman, I might just say at this juncture that there was, I think, an excellent article in Medical World News of July 22, 1985, that references Dr. Horn and this particular point, and I would like to ask unanimous consent that immediately following her testimony, that be made a part of the record.

Chairman HEINZ. Without objection, so ordered—though I may have put it in the record at the last hearing; I am not sure. But if it is the one I think it is, it is worth being in twice.

[The prepared statement of Susan D. Horn follows:]

PREPARED STATEMENT OF SUSAN D. HORN, PH.D.

The introduction of prospective payment of hospitals, based on DRG classification, has been a positive initial step toward cost containment in the health care industry. However, the experience gained by operating the prospective payment system over the last two years indicates that there are important ways in which it can be improved. In a prospective payment system based on fixed payments per case within a group, common sense demands that patients classified together should have similar resource requirements. Large variability of resource consumption within groups leads to financial risk for hospitals, undesirable incentives for poor quality of care, and unintended opportunities to profit through patient selection mechanisms.

Research has shown that most DRGs classify together patients who require widely different resources (*1, 2, 3*). This is reflected by the fact that the DRGs explain only about 30% of the variation in hospital resource use per case (*1, 4, 5, 6, 7*).

Further research has confirmed the clinical intuition that differences in the severity of illness of patients explain a large part of the remaining 70% of the variation (*4, 5, 6*). Several examples will illustrate this point. Figure 1 demonstrates how the average cost per case for patients in DRG 403 (Lymphoma or Leukemia, Age > 70, and/or Complication or Comorbidity) varies both by severity of illness and by whether or not the patient had an operating room procedure. Neither factor is recognized within this DRG.[1] Hospitals that treat proportionately greater numbers of the more severely ill can be substantially under-paid in this DRG. A hospital receives about $4000 for each patient in DRG 403, although this hospital's average cost per patient in DRG 403 was $6288.

A common disease among the elderly, Chronic Obstructive Pulmonary Disease, (DRG 88) is represented in Figure 2. The data are from two hospitals; Hospital A is a university teaching hospital with an average cost per case of $2703, and Hospital B is a community hospital with an average cost per case of $5078. The community hospital's average cost is almost twice that of the university teaching hospital because the patients in the community hospital are more severely ill. There are nine patients in severity levels 3 and 4 in Hospital B, while there is only one such patient in Hospital A. Thus, adverse impact of severity of illness differences in DRGs is not restricted to university teaching hospitals. Type of hospital is not the issue, but rather the type of patient. The current DRG-based prospective payment system, even with its multiple adjustments for teaching status, urban and rural status, proportion of indigent patients, and tertiary referral center designation (all attempted surrogates for severity), does not adequately recognize this (*4, 5, 6, 8*).

These are not atypical examples. In a recent study funded by HCFA, 94% of the DRGs were found to contain a wide variation of severity (*4, 5*). The result is that when hospital payments are based on DRGS alone, some hospitals will be greatly over-paid and others will be greatly under-paid (*4, 6*). This is demonstrated in Figure 3, where we have simulated paying each of 14 studied hospitals on the basis of an unadjusted DRG payment system, shown in red, and on the basis of a severity-adjusted DRG payment system, shown in blue. Both payment mechanisms are budget neutral: the total amount of money paid out to the 14 hospitals is the same under both systems. However, unadjusted DRGs result in much greater over-payments and under-payments than severity-adjusted DRGs (*4, 6*). The severity-adjusted system is fairer, relies less on internal cross-subsidization, and sends rational market signals to the hospitals.

If the DRGs were adjusted for severity of illness, many of the disincentives in the current prospective payment system could be diminished or eliminated altogether. In particular:

1. Hospitals treating a less severely ill case load would not be unduly rewarded; this over-payment under the present DRG system provides no incentive for the efficient production of services.
2. Hospitals treating a more severely ill case load would not be unduly penalized; patients who are more severely ill have justifiably higher costs which must be paid for somehow if these hospitals are not to be bankrupted and our national treatment system destroyed.
3. There would be no incentive to over-admit less severely ill patients, since the level of payment for such patients would be reduced.
4. The incentive for premature discharge of sicker patients, or "dumping" of the more severely ill, would be reduced if the justifiable extra costs of caring for such patients were appropriately paid for.
5. Improved control of resource use would result from a more accurate matching of resource requirements to each patient's burden of illness. One hospital now using severity of illness classification for internal management has estimated that as much as 30 percent of variable costs could be saved by evaluating resource use by severity level.
6. Atypically high patterns of resource use at the hospital level or at the physician level can be more easily identified, and then corrected, when severity grouping is used.

Prospective payment has, in principle, many excellent incentives to control health care costs. However, steps to control or reduce costs should be equitable and should provide incentives to maintain high quality care. A patient classification system used for prospective payment should be fair and should accurately describe a patient's resource needs. It is clear that DRGs alone are too coarse for this purpose, and research has shown that the surrogates now being used for severity of illness, such as teaching status, urban or rural status, proportion of indigent patients, and tertiary referral center designation, do not adequately address the differences. If DRGs were modified by a severity of illness adjustment, a large part of the present inequity in payment could be avoided, all hospitals would have improved incentives to deliver efficient and high quality care, no matter what the age or wealth of the patient, and government expenditures for hospitalization could be more effectively restrained.

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[1] Patient severity is quantified by a four-level scale of increasing severity from level one to level four. Procedures are classified into three groups: non-operating room, moderate operating room, or major operating room, according to a fixed table for all procedures.

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[Subsequent to the hearing the following article by Susan D. Horn was submitted for the record:]

DRG Reimbursement Unfair to Hospitals?

Johns Hopkins study says current rates fail to assess individual patients' degree of illness and cost of care needed.

Washington—DRGs' failure to reflect differences in severity of illness among patients within the same classification raises serious questions about equitable reimbursement for the nation's hospitals under the prospective payment system, Johns Hopkins researchers assert.

Investigators from various areas of the university—including public health, surgery, and medicine--believe their study of the problem is the first large-scale examination of DRGs, the linchpin of the government's prospective payment system. Moreover, a second study, to be published this fall, suggests that the disparity in illness severity may be responsible for overpayments and underpayments to teaching and community hospitals.

"For prospective payment to work equitably," principal investigator Susan Horn said at a news conference here, "a need exists for a good definition of patients and patient illness . . . not just patches on the system to get at the same issues."

Dr. Horn, an associate professor of health and management, said the system "could be materially improved" by adjusting the 467 DRGs according to a severity-of-illness index.

The Johns Hopkins researchers used such an index, developed over the past five years, to compare patients admitted for medical, surgical, obstetric, gynecologic, and pediatric care in a total of six hospitals—three university teaching hospitals, two community teaching hospitals, and one nonteaching community hospital.

A total of 57,245 patients were evaluated during a six- to 12-month period using the severity-of-illness index. Assigned to each patient at or after discharge by trained medical records personnel, the index removed the possibility of physician bias in arriving at a four-level score, with 1 the least severe rating and 4 the most severe, Dr. Horn said.

Severity was defined, she said, by seven dimensions chosen to reflect the burden of illness. These include

continued

the stage of the principal diagnosis at the time of admission, complications as a result of therapy or hospitalization, interactions with the patient's other preexisting medical problems, the degree of care needed by the patient, diagnostic and therapeutic procedures performed outside the operating room, the rate of the patient's response to treatment, and residual evidence of the disease or injury at discharge.

"The percentages of patients at the four severity levels differed significantly among the six hospitals and also between all paired hospitals," the researchers found.

"My colleagues say the findings of our study are obvious," said Dr. Gregory Bulkley, an associate professor of surgery and co-author of the report—published earlier this month in *The New England Journal of Medicine*. But he added that the data provide "the first clear-cut confirmation of the fact that patients with the same diagnosis are not ill to the same degree."

And yet, as the DRG system works now, he added, the severity of patient illness may differ dramatically, but reimbursement rates to hospitals are the same under Medicare.

'There would be no need for the government to spend more money . . . just distribute the money differently and more fairly.'

The burden this places on teaching hospitals, according to the researchers, is well recognized by the Health Care Financing Administration, which allows outlier and teaching adjustments to DRG rates to compensate for higher patient care costs.

But this approach is based on the "unsupported assumption" that these higher costs are due to research and teaching, the Johns Hopkins team said at the conference. However, "our study shows the reason for these higher costs is the greater burden of illness demonstrated by the type of patient who's referred to a teaching hospital."

Moreover, Dr. Horn noted, the teaching status of a hospital alone wasn't found to be "predictive of severity of illness" of its patient population. In rating the six hospitals after adjusting DRGs for severity of illness, she said, the nonteaching community hospital had a very severe case mix despite a low resident-to-bed ratio. But the teaching hospital with the highest resident-to-bed ratio also had the fewest severely ill patients of the three university institutions.

Because the government ranks hospitals according to the ratio of residents to beds, this suggests "the current reimbursement strategy is discriminatory," Dr. Horn added.

In a related study, scheduled for publication later this year, the Johns Hopkins team indicated that it had found inequities in the actual reimbursement rates as compared with the actual extent or severity of illness of the patient population. Both "gross overpayments and substantial underpayments" were made to teaching and community hospitals, they said.

Some institutions, Dr. Horn noted, received as much as 59% too much, whereas others received 25% too little in relation to the care rendered.

The severity-of-illness index that Johns Hopkins developed is used by more than 40 medical centers and hospitals nationwide for internal administration and quality control. These include Stanford, New York University, Northwestern, Duke, Tufts, and the universities of Alabama, Kentucky, Massachusetts, Minnesota, and Pennsylvania.

"This index could be applied to the set payment level within the DRG system," Dr. Horn contended. "There would be no need for the government to spend more money . . . just distribute the money differently and more fairly." ■

List of diagnosis related groups (DRGs), relative weighting factors, geometric mean length of stay, and length of stay outlier cutoff points used in the prospective payment system

DRG	MDC	Title	Relative Weights	Geometric Mean LOS	Outlier Threshold
176	6 MED	Complicated peptic ulcer	9333	6.3	23
177	6 MED	Uncomplicated peptic ulcer >69 and/or CC	6642	5.4	18
178	6 MED	Uncomplicated peptic ulcer < 70 w/o CC	5624	4.6	15
179	6 MED	Inflammatory bowel disease	9896	7.0	24
180	6 MED	G.I. obstruction age >69 and/or CC	7625	5.4	22
181	6 MED	G.I. obstruction age < 70 w/o CC	5872	4.5	18
182	6 MED	Esophagitis, gastroent. + misc. digest. dis. age >69 + /or CC	6036	4.7	18
183	6 MED	Esophagitis, gastroent. + misc. digest. dis. age 18-69 w/o CC	5135	4.0	15
184	6 MED	Esophagitis, gastroenteritis + misc. digest. disorders age 0-17	5428	2.8	14
185	6 MED	Dental + oral dis. exc. extractions + restorations, age >17	7160	4.3	21
186	6 MED	Dental + oral dis. exc. extractions + restorations, age 0-17	4112	2.9	11
187	6 MED	Dental extractions + restorations	4225	2.3	7
188	6 MED	Other digestive system diagnoses age >69 and/or CC	7110	4.3	21
189	6 MED	Other digestive system diagnoses age 18-69 w/o CC	5312	3.3	17
190	6 MED	Other digestive system diagnoses age 0-17	9611	4.5	22
191	7 SURG	Major pancreas, liver + shunt procedures	4.4168	17.9	35
192	7 SURG	Minor pancreas, liver + shunt procedures	3.9294	16.2	33
193	7 SURG	Biliary tract proc. exc. tot. cholecystectomy age >69 + /or CC	2.8129	15.6	33
194	7 SURG	Biliary tract proc. exc. tot. cholecystectomy age < 70 w/o CC	2.1151	12.4	29
195	7 SURG	Total cholecystectomy with C.D.E. age >69 and/or CC	2.2598	13.1	30

A sampling from the government's list of 467 groups: The Johns Hopkins researchers believe DRG limitations cause reimbursement inequities.

Chairman HEINZ. Vita.

STATEMENT OF VITA OSTRANDER, PRESIDENT, AMERICAN ASSOCIATION OF RETIRED PERSONS, WASHINGTON, DC

Mrs. OSTRANDER. Thank you, Mr. Chairman, for this opportunity to share with you the views of AARP on the impact of the Medicare prospective payment system on the quality of care.

We not only want to thank you, the committee, but also the efforts of all of your staff who have been seeking the facts about quality under PPS.

AARP's recommendations are: If PRO's are truly to become the guardians of quality under Medicare, a great deal of work remains to be done to develop useful measures for evaluating quality. The monitoring system as it now stands does not address the system's incentives to undertreat. It falls short of having the capacity to identify compromises in quality care and is even less successful at correcting substandard care.

To improve the Medicare quality assurance program, AARP recommends the following areas for change: Strengthen the PRO's; improve data collection and dissemination; target quality issues for further research, and strengthen the consumer involvement in the Medicare quality assurance program.

First, HCFA must demonstrate its commitment to quality of care review by substantially increasing the scope of review for quality and funding it accordingly. PRO's must be allowed the flexibility and given incentives to innovate, to experiment with new medical review criteria, data profiling strategies, physician feedback mechanisms, physician training, and consumer education ideas.

Moreover, HCFA's evaluation of PRO performance must encourage and reward innovation in quality of care review and enforcement.

Second, the initial focus of quality review is on hospital inpatients. Quality review must not be limited, however, to just the inpatient setting. Reductions in length of stay, increases in patient transfers, and greater use of outpatient services all point to the need for monitoring ambulatory and postacute care settings, too.

Third, the monitoring mechanisms currently in place to detect premature discharge must be broadened. Limiting review of hospital readmissions to only those readmissions within 7 days of discharge is too short. There is no monitoring of emergency room visits within any period after discharge, and no review of skilled nursing care or home health care services. The review for quality of care must reach far enough to pick up incidences of premature discharge, whatever the discharge destination.

Fourth, AARP supports Senator Heinz' bill, S. 1623, incorporated in the Senate's fiscal year 1986 budget reconciliation package which allows PRO's to deny reimbursement for substandard care.

Fifth, the current appeals process for continued stay denials is deficient. In too many instances, Medicare benefits are terminated before the beneficiary receives a hearing. A basic commitment to quality care would require an appeals process capable of testing decisions to deny or stop coverage on a case-by-case basis before benefits are terminated

Sixth, greater access to information for PRO's and for the general public is essential for an effective quality review program. PRO's must be funded to provide access to and integration of multiple databases. Moreover, new ways of presenting PRO-generated data in furtherance of the public interest and informed consumers must be developed.

Seventh, vitalizing the commitment to quality health care will require greater research on a variety of concepts on how to achieve quality. Measures to account for case complexity and severity must be refined so that they are easily used and sufficiently descriptive of the differences between patients under the same DRG.

Eighth, patients' health care outcomes must be monitored over time with the focus on such areas as functional status upon admission, change in patient status as of discharge, the effect of shorter length of stay on discharge destination, and the postdischarge experience.

Ninth, the wide variation in the way physicians practice medicine across the country has a major influence on both the cost and the quality of health care. AARP supports allocating a small fraction of 1 percent of the HI trust fund's annual revenues for research into these practice variations. The information collected should be fed back to the physicians, studied for their analysis and explanation of the differences. Even small successes in smoothing out these practice variations will reap dividends in savings and improved care.

Tenth, consumer involvement is important to the Medicare Program. Under current law, however, consumer involvement in the rules and regulations that define the limits of the program is strictly at the pleasure of the administration. AARP believes that consumer involvement in these very important issues must be statutorily assured by making Medicare subject to the publication, notice, review, and comment requirements of the Administrative Procedures Act. Subjecting Medicare to the APA requires HCFA to publish Medicare rules and regulations for public review and comment, thereby providing beneficiaries with the opportunity to influence the administration of the Medicare Program.

The quality of care under Medicare is essential because other health programs follow Medicare, and it is indicative of what we provide for the citizens of our country.

Thank you.

Chairman **Heinz**. Vita, that is a compendium of thoughtful, far-reaching suggestions, and I thank you very much.

You have appeared before this committee on many occasions, and you always have a tremendous contribution to make. It is nice to have you back.

Mrs. **Ostrander**. Thank you.

[The prepared statement of Mrs. Ostrander follows:]

Prepared Statement of Mrs. Vita Ostrander

INTRODUCTION

Thank you Mr. Chairman for this opportunity to share with this committee the American Association of Retired Persons' views on the impact of the Medicare prospective pricing system on the quality of care. On behalf of the Association and older people across the country, I want to commend you Senator Heinz, this committee and the fine staff for vigorously seeking the facts about quality under Medicare's prospective pricing system. But for the efforts of the Congressional committees on aging, the erosion of the commitment to providing quality health care services to retired and disabled persons would still be obscured by HCFA's claims that quality has not suffered under PPS.

My testimony focuses on four areas: (1) The Health Care Financing Administration's (HCFA) failure to adequately appreciate the economic and administrative incentives under the DRG system to undertreat; (2) HCFA policies that fail to support the DRG system; (3) gaps in Medicare's quality assurance and monitoring programs; and (4) AARP's recommendations to improve monitoring and assure high quality care in the ambulatory, hospital and post-hospital setting.

1. HOSPITAL INCENTIVES UNDER DRGS

The DRG prospective payment system has dramatically changed the incentives to hospitals treating Medicare patients. Under the old cost plus system, hospitals were paid for each service provided. The more services provided, the more money the hospital received. Thus, it was in the hospital's interest to provide excessive services and to keep a patient hospitalized as long as possible. Under DRGs, those incentives are gone.

Under DRGs, hospitals have the opposite incentives—to perform fewer services and to get Medicare patients out of the hospital as soon as possible in order to maximize their "profit." Moreover, new administrative rules and policies under DRGs limit Medicare patients' access to certain kinds of care and medical procedures.

For example, HCFA requires PROs to reduce identified procedures (the procedures vary from state to state) by specific amounts. PROs will be evaluated by HCFA based, in part, on how well they meet these numerical reductions. For most parts of the country, however, the target numbers are based on little or no evidence that the procedures identified can be safely reduced without precluding access to necessary care.

Moreover, HCFA requires PROs to strictly limit certain procedures to the outpatient setting, which is covered under Part B of Medicare and thus requires greater beneficiary cost sharing. Determining, however, which procedures are more appropriately handled inpatient versus outpatient is an extremely delicate issue, particularly in light of medical practice variations. Many patients over age 65 simply are not good candidates for certain types of outpatient surgery. Nevertheless, patients needing a procedure that is required to be done on an outpatient basis have little choice but to incur the risk and expense associated with outpatient surgery, or simply forgo surgery altogether.

Thus, the incentives inherent in the DRG system combined with the new rules implementing it, substantially alter Medicare patients' rights under DRGs. This combination of structural incentives and administrative incentives jeopardize beneficiaries in two ways: (1) there is greater jeopardy to individual health status from skimping on services, and (2) there is greater financial jeopardy for services now deemed to be non-covered and for services moved from the inpatient to the outpatient setting where greater cost sharing is required.

The Administration and the Congress must understand that these incentives are hurting Medicare patients. Although only anecdotal evidence is currently available to describe the effect of DRGs on patients, such evidence continues to mount.

EVIDENCE THAT DRGS ARE HARMING PATIENTS

In February, 1985, the House Select Committee on Aging held a joint hearing with the House Task Force on the Rural Elderly. The subject of the hearing was the quality of care under DRGs. Witnesses testified about problems of early discharge and lack of post-acute care services. One witness, a discharge planner for a large hospital in Minneapolis, told about the difficulties she had maintaining hospital care for her sick mother because the small rural hospital claimed her mother's allotted days of care under the DRG had run out. Fortunately, the witness was knowledgeable about DRGs and was able to fight the hospital. Unfortunately, not all Medicare beneficiaries or their families are as familiar with the system and, therefore, are much more likely to acquiesce in the hospital's decision.

On February 26, 1985, the Senate Special Committee on Aging released a report from the General Accounting Office on the impact of Medicare's new prospective payment system on post-hospital care. The report showed that Medicare patients are being discharged "quicker and sicker," too often with no place to go.

On September 26th and October 24th of this year, the Senate Special Committee on Aging held hearings to examine the quality of health care provided to Medicare patients under PPS. Testimony at those hearings, from hospital and nursing home administrators, physicians, long-term care ombudsmen and representatives of peer review organizations, showed that PPS has both created and multiplied quality and access problems for Medicare beneficiaries.

The American Association of Retired Persons is also trying to evaluate the scope and breadth of the problems affecting patient care under DRGs. The Association has received over 400 letters and numerous telephone calls from Medicare beneficiaries, their children, nurses, and social workers complaining about poor care and premature discharge under DRGs. The story that follows is illustrative of the anxiety and frustration encountered by Medicare beneficiaries and their families under the DRG prospective payment system. It provides a good example of the kind of mail the Association has received on the DRG system. It was written by a 71 year old Medicare beneficiary in Texas. She is a retired R.N., with an artificial heart valve, writing about her own unhappy experience.

She was admitted to the hospital because of a high temperature caused by an upper respiratory infection. Her artificial heart valve was an additional dimension of concern indicating hospitalization. After being admitted she developed problems breathing and was placed on continuous oxygen and inhalation therapy three times a day. The night of her third day in the hospital, inhalation therapy was required for the entire night. In addition, although she was expectorating "thick, purulent matter, tinged with blood," no one at the hospital was concerned enough to investigate.

On the morning of the fourth day in the hospital, her doctor announced she was going home. When she protested, he said that the hospital had a new policy and that they now determined how long a Medicare patient could stay. She writes that her doctor was very upset—even "intimidated" by the hospital. He told her not to fight the hospital. She stated her fears about a relapse or dangerous complications, and refused to go home until her temperature was normal for 24 hours.

On the morning of the fifth day, the hospital's head nurse ordered her to go home and threatened, if she did not leave, to move her to a special floor with no heart or lung equipment and minimal nursing care; for such minimal care the patient herself was to be charged $65 per day. She was finally discharged the following morning.

After five weeks of recovering at home, she investigated the new Medicare DRG system and learned, among other things: that the hospital has a medical review board consisting of doctors, nurses, and other hospital personnel, but (1) that, in her case, it was a medical librarian who made the decisions about how long she should stay, and

(2) that doctors are pressured to discharge patients as the hospital dictates.

2. CONTEMPORANEOUS HCFA POLICIES THAT UNDERMINE THE DRG SYSTEM

HCFA policy decisions on other issues are having an adverse impact on Medicare patients under the DRG system. Apparently, HCFA does not appreciate the power of the incentives under DRGs to discharge patients "quicker and sicker." HCFA is pursuing policies that foreclose increased access to post-acute care services instead of fostering it.

Access to skilled nursing home care has long been the forgotten promise of Medicare. For a variety of reasons, skilled nursing facilities (SNFs) have not been a reliable benefit for Medicare beneficiaries. Congress, in hopes of encouraging more SNFs to become involved in Medicare, provided a mechanism for "cushioning" SNFs against wrong decisions about whether a patient is covered for SNF care. This "cushion" is called the waiver of liability. It is a presumption that a SNF acts in good faith if incorrect coverage decisions represent five percent or less of the providers' Medicare case load. If a SNF meets the presumption, then Medicare will pay for the uncovered services.

In a recent notice of a proposed rule, HCFA eliminates the waiver of liability by eliminating the presumption of good faith. The result of this change will be to further discourage SNFs from taking Medicare patients, thus making it even more difficult for post-acute care patients to get the skilled care that they need.

The elimination of the waiver of liability affects home health care providers too. Beyond the waiver problem, however, home health care providers face additional HCFA policies that have made access to home care more difficult. HCFA has created a form of denial that does not exist in Medicare law or regulations called "technical denials". A "technical denial" is the denial of payment for a home health visit based on the fiscal intermediary's (FI's) determination that the visit failed to meet a statutory or regulatory requirement, other than medical necessity. "Technical denials" are not subject to the waiver of liability and are not appealable by the home health provider. FIs make "technical denials" when they determine that a patient did not meet the "homebound" or in need of "intermittent care" eligibility requirements under Medicare's home health benefit. The interpretation of these terms is so restrictive that even the sicker patients coming out of hospitals under the DRG system are having trouble qualifying for post-acute care services at home. Home health agencies are harmed by "technical denials" because they must absorb the cost of the services rendered.

These conflicting, contemporaneous policy directions reduce the availability of post-acute care services necessary to accommodate Medicare patients under DRGs. Hence, Medicare patients are being discharged from Hospitals into a no-cure zone.

The current post-acute care situation for Medicare patients can be compared to the deinstitutionalization of mental hospital patients in the 1970s. In the 1970s it was considered good public policy to close mental hospitals and serve those patients in the community. The only problem was that a community-based mental health care system did not exist to serve them. As a result, the lucky deinstitutionalized patients ended up in nursing homes under Medicaid; the unlucky ones ended up on the streets or in the criminal justice system. The Association will not sit idle while Medicare patients are forced out of hospitals still needing care and without any place to go. If policymakers cannot provide the post-acute care services necessary for patients under the incentives of the DRG prospective payment system, then it is time to change the system.

3. GAPS IN MEDICARE'S QUALITY ASSURANCE AND MONITORING PROGRAM

HCFA's failure to coordinate policies between the acute care and post-acute care settings, resulting in restricted access to post-acute care services relative to need, most certainly be considered a major gap in quality under the Medicare program. But even for those Medicare patients lucky enough to traverse the fiscal intermediary's maze of technical requirements and actually receive post-acute care services, there is no mechanism to assure that they will receive quality care. Under current law there is no program to review quality for an entire episode of illness, from admission through post-acute care. Thus, skilled nursing home and home health care patients are not assured of receiving quality care. Moreover, PROs do not have authority to review care in the ambulatory setting. Considering the shift of services from the inpatient to the outpatient setting, this lack of jurisdiction is a major loophole in the quality of care review process.

The absence of review of quality of care in the ambulatory and post-acute care settings represents important gaps in Medicare's quality assurance and monitoring program. But gaps in Medicare's quality assurance and monitoring program are reflected as much in the subtle details of the program, as in the program's omissions.

(A) The quality review requirements in PROs' scope of work regulations are narrow, arbitrary and, in some cases, dependent upon data that is simply not available. HCFA requires PROs to pursue at least one quality objective in each of five areas. While the five areas identified by HCFA represent legitimate areas of concern over quality, they do not require the creation of quality assurance monitoring mechanisms at the places in the system where the incentives not to provide adequate, appropriate or quality services are greatest. Monitoring is essential to determining whether the services provided are adequate and appropriate, i.e., whether they represent an acceptable level of quality.

(B) In addition to the weak quality objectives required under the PROs scope of work, the nature and emphasis of the PRO review process itself must be considered a gap in the Medicare quality assurance program. The PRO review emphasis is clearly on the financial issues of concern to HCFA and not on the quality of care issues that are important to beneficiaries. This emphasis is demonstrated in the funding of full time equivalents doing utilization review as opposed to quality of care review.

It is further demonstrated by the lack of funding for PROs to pursue cases of substandard quality. Pursuing such cases is costly because they involve a great deal of physician time and preparation. Moreover, such cases are almost always litigated by the hospital and physician(s) involved, this requiring even more expensive professional review time. HCFA's failure to provide PROs with the resources to pursue these cases practically assures that they will not be pursued.

AARP believes that HCFA must reevaluate its approach to quality of care issues through the PROs. PROs must be allowed the flexibility and given incentives to innovate—to experiment with new medical review criteria, data profiling strategies, physician feedback mechanisms, physician training, and consumer education ideas.

(C) Another gap in HCFA's quality assurance and monitoring program is in the area of data. Comprehensive, timely, and accurate data is essential to an effective review system. The scope and quality of PRO data will directly affect the ability of the PRO to maintain quality care, as well as control costs.

AARP questions the wisdom of forcing PROs to use claims data from Medicare fiscal intermediarys (FIs). Much must be done to improve the accuracy and adequacy of FI data for review purposes. AARP supports the development of a uniform collection and processing system that meets the needs of both FIs and PROs. Until such a system is operational, however, PROs must be permitted to secure access to information beyond Part A claims files.

(D) Finally, the appeals procedures under the PPS provisions of Medicare do not provide a realistic or meaningful opportunity for beneficiaries to raise quality of care issues connected with discontinuance of a hospital stay. Perhaps the most egregious omission in the appeals procedure is the fact that a beneficiary's right to appeal the decision to discharge him/her from the hospital does not attach until the hospital intends to hold the beneficiary financial liable for the continued stay. Hospitals recognize that Medigap insurance does not cover hospital stays not covered by Medicare. Thus, hospitals know that once a patient has been given a formal "notice of noncoverage", Medigap insurance will not be available to cover the continued stay.

In order to avoid the time and expense of pursuing Medicare patients owing the hospital for a non-covered stay, the law allows hospitals the option of not issuing a "notice of noncoverage" by simply telling the patient to go home. A variety of informal pressures are available to hospitals to coerce patients reluctant to be discharged, and without a formal notice the patient has no right of appeal. This is a glaring hole in the quality assurance and monitoring program for Medicare beneficiaries.

4. RECOMMENDATIONS FOR IMPROVED MONITORING OF QUALITY OF CARE UNDER PPS—STENGTHENING THE PROS

If PROs are to truly become guardians of quality, a great deal of work remains to be done to develop useful measures for evaluating quality of care. Moreover, the monitoring system as it now stands does not appreciate the system's incentives to undertreat; it falls short of having the capacity to identify compromises in quality care and is even less successful at correcting these compromises. With those shortcomings in mind, AARP recommends the following:

1. The commitment to quality of care review by the PROs must be demonstrated by HCFA. First, funding levels for the second round of PRO contracts must reflect a substantial broadening of the scope of review for quality of care. Second, the criteria for evaluation of PRO performance by HCFA must encourage and reward innovation in quality of care review and enforcement.
2. Generic quality screens must be incorporated into the standard review process to assist the PROs in the identification of quality problems. These quality screens should supplant the narrow, arbitrary, and difficult to validate quality objectives that are currently a part of the PRO scope of work.
3. While the initial focus of quality review is on hospital inpatients, examination must not be limited to just the inpatient setting. Reductions in the length-of-stay, increases in patient transfers and greater use of outpatient services all point to the need for monitoring ambulatory and post-acute care settings. Since nursing home and home health care are fast becoming an integral part of the acute care system, quality review must also be focused on these services.
4. The monitoring mechanisms currently in place to detect premature discharge must be significantly broadened. The use of 7 days as the basis for review of readmissions is too short. Moreover, there is no monitoring of beneficiary need for emergency room services after a hospital discharge. And, as just stated, this review must extend to post-acute care settings.
5. AARP supports Senator Heinz' bill (S. 1623), now part of the Senate's FY '86 Budget Reconciliation Package (S. 1730), which allows PRO to deny reimbursement for substandard care.
6. As a safety net for quality of care problems the Part A appeals process must be reformed to contribute more to the quality assurance and monitoring program. The current appeals process for continued stay denials is deficient. The timing and content of the hospital "notice of noncoverage" raises many questions. The unavailability of appeal rights until the patient places himself at financial risk is causing the patient to leave rather than challenge a denial of benefits. If the patient is not willing or unable to risk his own funds, he will be discharged and there will be no expe-

dited review. Thus, in too many instances, Medicare benefits are terminated before the beneficiary receives a hearing. A basic commitment to quality care would require an appeals process capable of testing decisions to deny coverage on a case by case basis before benefits are terminated.

7. Finally, AARP will continue to press for a stronger consumer role in the implementation of the PRO program. A first step has been taken with the election of AARP-supported consumer members to the boards of seven PROs. The consumer-PRO relationship must be extended through board memberships, as well as a much more visible PRO effort to educate the beneficiary community about their rights and responsibilities under the Medicare Program.

THE NEED FOR DATA

Accessible, comprehensive data is essential to the tasks of both conducting quality review and evaluating its effectiveness. Therefore, AARP recommends the following:

1. PROs must be funded to support access to and integration of multiple data bases. AARP agrees with the American Medical Peer Review Association (AMPRA) that the PROs' analytic potential can only be maximized by increased access to information systems beyond Part A claims data.
2. We must continue to find ways of presenting PRO-generated data in furtherance of the public interest in better informed consumers. AARP is not satisfied with the current data disclosure regulation. Public access to information is critical to making patient care choices and evaluating health care delivery.
3. HCFA must look closer at the so-called "Part B cost shift." The critical question to be answered is whether the savings in Part A result from a shifting of expenditures to Part B and to beneficiaries.

RESEARCH IN QUALITY OF CARE

In the past, the commitment to quality health care was assumed by the presence of abundant resources. But skyrocketing health care costs made the need for cost containment pressing. The resultant DRG prospective payment system established a new set of financial incentives. Accompanying the incentives to reduce the hospital cost of each inpatient stay is the incentive to undertreat. Grappling with the real and potential quality of care problems under the new system brought to light the need to know more about quality of care. To help focus that light, AARP supports the following research agenda:

1. Measures to account for case complexity and severity must be refined so that they are easily used and sufficiently descriptive of the differences between patients within the same DRG. Such refinement represents the next generation of quality review and must undergo experimentation for eventual implementation nationally.
2. Longitudinal studies of patient care. Patient health care outcomes must be monitored over time with the focus on such areas as functional status upon admission, changes in patient status as of discharge, the effect of shorter lengths of stay on discharge destination, and the post-discharge experience.
3. Measurements for quality of care should be studied to develop meaningful outcome measures. Specifically, the relationship of outcomes of medical care to the process of delivering care and the structural characteristics of providers should be examined.
4. AARP supports legislation that would allocate a fraction of one percent of the Medicare Part A Trust Fund for research into medical practice variations. For the past several years, researchers have been tracking variations in the use of medical care and have begun to discover "systematic and persistent" variations in the standardized use rates for common surgical procedures as well as other services. These variations seem largely to be the result of what has been called "the practice style factor" which strongly influences not only the form of treatment undertaken, but the setting in which the treatment occurs. AARP recognizes the need for greater information about clinical outcomes and statistical norms based on average performance.

STRENGTHENING CONSUMER INVOLVEMENT IN THE MEDICARE PROGRAM

ARRP believes consumer involvement is an important factor in the development of the Medicare program. The Association is proud and enthusiastic about the beginning that has been made with consumer representation on the boards of directors of seven PROs, as well as the Board of Directors of the American Medical Peer Review Association. But consumer involvement is important in all aspects of the Medicare program, it is the foundation upon which public support is based. AARP believes that consumer involvement in the Medicare program must be statutorily assured by making Medicare subject to the Administrative Procedures Act. Consumers cannot fulfill their responsibility to Medicare if the policies, rules, and regulations governing Medicare can be made in secret and transmitted to Medicare's agents—carriers and fiscal intermediaries—without consumers knowledge and ability to review and comment? Requiring HCFA to publish Medicare rules and regulations for public review and comment provides beneficiaries with the opportunity to influence the program before decisions about it are implemented. The publication, review and comment requirements of the APA will help keep HCFA from using nonstatutory or nonregulatory rules—such as "technical denials" as a basis for denying Medicare benefits to beneficiaries who need them.

Elliot Richardson, when he was Secretary of Health, Education and Welfare, made a voluntary commitment to subject Medicare to the APA. This Administration has abandoned that commitment. It is time to revitalize that commitment by mandating that Medicare comply with the APA.

CONCLUSION

Thank you again Mr. Chairman for your leadership in the cause of maintaining quality care under the Medicare program. My Association's interest in this area is not a selfish interest, an interest just in ourselves. We believe a simple truth binds the generations together in the quest for quality health care. That simple truth is this: The quality, or lack of it, of care under Medicare is ultimately indicative of the standard of care for most everyone else in our country. For Medicare is the flagship of the American health care system—where it leads others follow. The issues of concern to Medicare beneficiaries today, will be the issues of concern to all health care consumers tomorrow.

Chairman HEINZ. Judy Waxman.

STATEMENT OF JUDY WAXMAN, NATIONAL HEALTH LAW PROGRAM, WASHINGTON, DC

Ms. WAXMAN. Thank you, Mr. Chairman.

My name is Judy Waxman. I represent the National Health Law Program, which is a national support center, funded primarily by the Legal Services Corporation to provide assistance to low-income persons on issues concerning access to health care.

We respond to approximately 2,500 requests for assistance each year. As lawyers, we have received or been advised of a sizable number of complaints by individual Medicare beneficiaries, who complain of hospital discharge practices. Remarkably, the complaints are in similar form. What we hear is that hospital representatives tell the patient or the family member that the patient must leave the hospital in short order, usually in a day or two, because the Medicare coverage has "run out." This practice occurs in many instances whether or not more hospital care is needed. The communications from the hospital officials are word of mouth; there is no written notice.

Why does the problem exist? As we heard this morning, the DRG system has dramatically revised how reimbursement is made to hospitals, but the entitlement to coverage has remained essentially the same. Yet, since the system has begun, we hear hospital representatives and doctors saying that hospital coverage only lasts 6 or 10 days, et cetera.

We think a major contributing factor to this misunderstanding is the lack of familiarity by many people with the actual coverage rules. That includes doctors, as you, Senator, mentioned yourself this morning.

Certainly, few beneficiaries know anything about their coverage rights, are told virtually nothing when they arrive at the hospital, and, in addition, would find it extremely difficult to assert their rights even if they did know them.

Unfortunately, there is little under present law and policy which helps their plight. The most important existing vehicle for monitoring quality of care is the PRO. However, PRO's only review hospital-initiated discharges in very limited situations.

HCFA has published one regulation concerning hospital initiated discharges. In fact, they do require that the beneficiary get a written notice when the Medicare coverage will end if the patient will be charged. I do want to disagree with Mr. Haddow's earlier interpretation of this regulation. In fact, HCFA has provided that the notification only go to those individuals when a bill will be presented to that person. The notice never goes—or at least, it has not, as far as we have seen in our experience, gone to individuals when they are just asked to leave.

We think that the legality and the wisdom of that policy is subject to grave doubt. We think that the protections in the regulation, and even more protections, should in fact be extended to all beneficiaries.

In some individual cases in which we have been involved, relatives of patients have called us and asked, "What happens now? My relative is being asked to leave the hospital." We have advised them to ask for the notice, even though we know it is not technically required if the patient is not going to be charged. In every case, as far as we know, when the hospital has been asked to provide such a notice, they have, quote-unquote, "reconsidered" their decision, and the individual has been allowed to stay in the hospital and not be discharged as threatened.

We do believe that the intervention of informed advocates or relatives really does make a difference, but such assistance is currently available in only a miniscule percentage of cases because few people are aware of these rights, and the law and the policy fails to promote that awareness.

Mr. Haddow also said earlier that only 4,500 PRO reconsiderations are on record, and that indicates to him that there is not a systemic problem.

I would like to disagree with his conclusion for a number of reasons. First, the reason there are not a lot of reconsiderations is that people do not know they can ask for it. Additionally, HCFA does limit the situations in which a person can ask for the reconsideration. Last, the vast majority of those reconsiderations that he cites are actually hospital-initiated reconsiderations. The number of patient-initiated reconsiderations, as far as we can determine, is extremely small—which leads me to a couple of suggestions we wanted to make.

The first suggestion is the obvious one. We think all patients should be required to receive a notice whenever they are being asked to leave the hospital if they think a discharge is not appropriate, whether or not they are told they will be billed. We think such notices would increase beneficiary awareness and also produce a valuable database for us to determine in fact, how the DRG system is working.

In addition, the rights themselves should be strengthened. Our written testimony includes quite a few suggestions, in this regard, and I will highlight just two. One, we think that beneficiaries should be entitled to some kind of hearing and decision, on continued coverage, within 2 days, so they will know what their liability will be before charges start to accrue.

Also, beneficiaries need more access to the PRO. They need to be able to initiate a request by calling the PRO or by talking to some hospital-based PRO representative so that the process can be expedited.

PRO monitoring and hospital discharge practices also must be improved, specifically by improving the handling of beneficiary complaints and appeals. We found that when advocates and lawyers actually speak to the PRO regarding an appeal, the staff often do not know what process they are supposed to follow. HCFA has very limited guidelines on PRO appeals procedure, and should immediately issue more detailed guidelines on how reconsiderations should be handled.

Lastly, I do want to emphasize that, of course, the education of Medicare beneficiaries and other people in the health care system should be strengthened. I agree with your suggestion earlier, Senator, that hospitals should be required to educate patients and that this requirement should be raised to the level of a condition of participation. Possibly a violation of this requirement could be grounds for imposition of PRO sanctions.

We appreciate your interest and your concern in scrutinizing this problem and certainly would be happy to give any more information that you would need on this subject.

Thank you.

Chairman HEINZ. Ms. Waxman, thank you for some very good insights, and in particular, for setting the record a little straighter. We appreciate that.

[The prepared statement of Ms. Waxman follows:]

PREPARED STATEMENT OF JUDY WAXMAN

The National Health Law Program, Inc. [NHeLP] is a national support center, funded primarily by the Legal Services Corporation, which provides assistance to low income persons and their advocates throughout the country. We engage in ongoing research and study of the major health programs, respond to over 2,500 requests for assistance per year, and engage in a variety of writings, trainings and presentations.

One of our areas of specialization is the Medicare program. In addition to the activities noted we are co-sponsors of, and work with the Los Angeles-based Medicare Advocacy Project—which provides assistance to a large number of individual Medicare beneficiaries.

Within the spectrum of Medicare issues with which we have had contact, some of the most important have involved Medicare's Prospective Payment System (PPS) for hospitals, commonly referred to as the "DRG System."

In response to this Committee's request, we would like to focus our testimony on the problem of early discharges under the PPS, as affected by beneficiaries' lack of awareness of their rights. We have included some suggestions for reform.

THE GENERAL PROBLEM OF EARLY DISCHARGES

Before the DRG System was implemented; effective October 1, 1983, it was apparent to most informed observers that hospitals would have new incentives to discharge Medicare patients earlier than appropriate. Both your Congressional Office of Technology Assessment [1] and the Government Accounting Office,[2] among others, warned of this.

Indeed, during the past two years, as the system has been phased in (a large number of hospitals still receive only half of their reimbursement or less under PPS), complaints, surveys and reports from throughout the country have complained that many beneficiaries are being inappropriately discharged "quicker and sicker." These reports have come from sources as diverse as the GAO,[3] the American Society of Internal Medicine,[4] Long-Term Care Ombudsmen,[5] Area Agencies on Aging,[6] and various other accounts.[7] This Committee, and its parallel in the House of Representatives, have themselves reported such findings.[8]

It is fair to say that no one seriously disputes the gravity of this problem; at most there may be arguments as to its precise magnitude.

NHELP INVOLVEMENT WITH THE ISSUE

Like several other health advocacy and/or policy organizations, we have endeavored to monitor reported evidence of DRG problems, including the previously-noted studies and others less publicized. In addition, members of our staff have received similar reports orally, at various fora. As advocates, however, we have received—or been advised of by colleagues—a sizable number of complaints by individual Medicare beneficiaries complaining of hospital discharge practices.

The complaints usually assume a remarkably similar form: some hospital representative has told the patient and/or relative that they must leave in short order (commonly within a day). Commonly they are told that their Medicare coverage has "run out." The communications are by word-of-mouth; written "notice" is rarely involved.[9]

Such complaints have been raised to us in telephonic requests for assistance from advocates and relatives; by advocates at several training conferences (for example since June we participated in seminars in Philadelphia, New Orleans, Portland and Des Moines, involving some 275 advocates, at which the issue of inappropriate discharges under the DRG System was discussed); and at presentations to seniors groups made by our staff.

While most of the individual complaints inevitably involve discharges that had already occurred, in several instances we were able to assist advocates in intervening with hospital staff while a threatened discharge was actually pending. As best as we can tell, in each instance the threatened discharge was cancelled or delayed.

INADEQUACY OF INFORMATION

Although the DRG system dramatically revised the manner in which hospitals are reimbursed by Medicare, beneficiaries' entitlement to coverage remained essentially unchanged.[10] The primary basis for coverage is medical necessity for hospital-level care. In addition, though most people are unaware of this, eligibility for hospital coverage can also be based upon a need for skilled nursing-level care where no SNF bed is available.[11] This coverage entitlement has become increasingly important because—as this Committee's October 24, 1985 Staff Report summarized—the supply of adequate, available SNF beds has not kept pace with the need for them.

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[1] See OTA, Diagnosis Related Groups [DRG's] and the Medicare Program: Implications for Technology (July 1983).

[2] See, e.g., GAO Report, (GAO/HRD-83-62) (June 15, 1983); and GAO Report, "GAO Staff Views on the President's Fiscal Year 1984 Budget Proposals," (GAO/OPP-83-1) (Mar. 4, 1983), pp. 69-72.

[3] See GAO Preliminary Report, "Information Requirements for Evaluating the Impact of Medicare Prospective Payment for Post-Hospital Long-term Care Services," (GAO/PEMD-85-8 (Feb. 21, 1985).

[4] American Society of Internal Medicine, "The Impact of DRG's on Patient Care" (Oct. 1985). Over 45 percent of the survey's respondents agreed that there was hospital pressure to discharge patients "earlier than medically appropriate" or that such discharges were occurring. Fewer than 10 percent believed that "quality of care" had been improved.

[5] See House Select Committee on Aging news release (Mar. 29, 1985).

[6] See the study of the Southwest Long Term Care Gerontology Center and the National Association of Area Agencies on Aging, as reported in Medicare/Medicaid Information, Aug. 26, 1985, p. 4.

[7] See, e.g., " 'Dumping' of Patients Tied to Medicare Fees," L.A. Times (July 8, 1984); "Medicare Change Stirs Concern for the Elderly," L.A. Times (Apr. 14, 1985); "Data Gap Complicates Product Line Analysis," Hospitals (Sept. 16, 1984) p. 62.

[8] See, e.g., "Impact of Medicare's Prospective Payment System on the Quality of Care Received by Medicare Beneficiaries," Senate Special Committee on Aging (staff report) (Oct. 24, 1985); July 25, 1985 Letter of Hon. John Heinz to DHHS Secretary Margaret Heckler; "Health Care Cost Containment—Are America's Aged Protected?" July 9, 1985 hearing of the House Select Committee on Aging; Feb. 26, 1985 hearing of the House Select Committee on Aging.

[9] In a few cases we have encountered, hospitals did give patients (or their relatives) written notification, but the notices were defective in various respects, for example: they did not clarify appeal rights; they failed to advise patients of their right to two additional "coverage" days (see text discussion infra); and, in two instances, the notice was given to the patient—as they were leaving the hospital in response to the hospital's prior oral directive.

These coverage entitlement rules were essentially the same before and after the implementation of the DRG system. However before PPS, as has been well-chronicled, it was to hospitals' financial advantage to keep benficiaries as long as possible. They received full, hospital rates each day, including the SNF-level "alternate placement days." [12] After the DRG System was implemented the financial incentives were reversed. Not coincidentially, the proper coverage entitlement rules seem largely to have been forgotten.

Once the DRG System began, countless hospital representatives (and others) began to speak of Medicare hospital coverage as lasting only six, or ten, etc., days, or of ending when the DRG payments "ran out." These perceptions appear to be as pervasive as they are false; no such coverage rule changes occurred.

Why has turnabout taken place? In our view several factors have conspired to produce it. These would include: conscious design or ignorance on the part of hospital administrators; lack of familiarity by most people, including many doctors,[13] with the actual coverage rules; inadequacies in intra-staff education and communications; and a good deal of popular but inaccurate publicity about the DRGs.

It is well known that hospital administrators communicate to their staffs how much money is paid for each case and, often, the length of stays associated with each DRG. Messages of various types are conveyed that cases should not exceed those limits. This perception of health care is indeed encouraged by much current public policy which has declared health care is to be run as a competitive business.[14] Good businesses do not keep "stock" after its "shelf value" has declined. And, indeed, business has been very good for hospitals under the PPS—the industry has made "record" profits.[15]

Most advocates, journalists, and hospital staff, as well as many doctors, are unfamiliar with the proper coverage rules. Imagine, then, the plight of hospitalized beneficiaries, who are often infirm, and by definition in an extremely vulnerable state and to whom virtually nothing is done to communicate information about the appropriate coverage rules, or about appeal rights.

In our view, hospitals are regularly communicating the erroneous coverage rules to beneficiaries. They are doing so in the context of informing beneficiaries and/or their relatives that they must promptly leave the hospital. By definition, this is being done most often to the sickest and most vulnerable elderly, as these are the individuals whose hospitalizations are most likely to exceed the number of days or amount of money "assigned" to any DRG.

Few beneficiaries know anything about their coverage rights, and would find it extremely difficult to assert them if they did. Unfortunately, there is little under present law and policy which helps their plight.

INADEQUACY OF EXISTING BENEFICIARY PROTECTIONS

The most important, existing vehicles for monitoring quality of care under the PPS are the "Utilization and Quality Control Peer Review Organizations," popular-ly known as *PROs*. They perform a variety of admissions practice monitoring functions. Among these, their review of all prompt (within seven days) hospital readmissions has some potential for protecting against early discharges.[16] PROs do not however, review hospital-initiated discharges (except, as noted below, in limited situations—and even that limited review is of questionable value). PROs also have, as noted below, a role in monitoring some hospital-initiated discharges. They handle beneficiary appeals of these and other coverage-denial situations. As we observe in the recommendations section infra, there are questions about how effectively some PROs are carrying out these responsibilities.

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[10] See, e.g., the following excerpt from HCFA's preamble to the adoption of final PPS regulations, 49 Fed. Reg. at 282 (Jan. 3, 1984):

"The prospective payment legislation did not change Medicare coverage or eligibility rules currently in effect. . . . As a result, requirements relating to exclusions, physician certification and recertification, and national coverage rules continue to be applicable."

[11] Cf, e.g., 42 U.S.C. 1395x(v)(G)(1980); In addition beneficiaries are still limited to 90 days of coverage per "benefit period"—plus 60 "lifetime reserve days"—though extremely few beneficiaries require hospitalizations even half that long.

[12] See the preamble to Interim Final PPS regulations, 48 Fed. Reg. at 39777 (Sept. 1, 1983).

[13] Many doctors with whom we have had contact are unaware, for example, that the need for SNF-level care (where no SNF bed is available) is a basis for Medicare hospitalization coverage. And, for example, in the internist survey noted at fn. 4, supra, one respondent observed (incorrectly), "The length of stay allowed for acute leukemia hospitalization is less than 10 days . . ."

[14] See, e.g., Wallace, "Managing along product lines is key to hospital profits under DRG System," Modern Healthcare, Sept. 1983, p. 56.

[15] See, e.g., "Hospitals Score Record Profits Under DRGs," Medical Benefits, Aug. 31, 1985 (digesting an Aug. 9, 1985 American Medical News article by D. Lefton); and Anderson, "Majority of Hospitals are Better Off Under Prospective Pricing—Surveys," Modern Healthcare, Sept. 13, 1985.

The Department of Health & Human Services (DHHS)—through its Health Care Financing Administration (HCFA)—has long explicitly recognized the need to guard against inappropriate discharges under the PPS.[17] And, in adopting final PPS regulations in January 1984,[18] HCFA adopted a regulation—now codified as 42 C.F.R. 412.42(c)—providing for written notice, and appeal rights, in certain situations where hospitals seek to discharge Medicare patients as no longer needing hospital coverage.

That regulation sets forth a number of helpful-sounding protections, for example:

(a) It specifically articulates that entitlement to hospital care includes a continued need for SNF-level care where no SNF bed is available, 42 C.F.R. 412.42(c)(1);

(b) The attending physician (or, upon her or his refusal, the PRO) has to concur in the hospital's decision, 42 C.F.R. 412.42(c)(2);

(c) The beneficiary must be given a written notice, advising of these determinations and of appeal rights to the PRO, 42 C.F.R. 412.42(c)(3); and

(d) No charges can be assessed against the patient for at least two days[19] after the date of the notice (and the notice has to so state) 42 C.F.R. 412.42(c)(3)(ii).

As noted below, there are some specific problems with the provisons of the regulation. Most importantly, however, HCFA has provided that this notification process is not required in all cases where a hospital seeks to discharge a beneficiary; rather than it applies only where a hospital expressly notifies the beneficiary that it seeks to charge a beneficiary for a continued stay. In other words, it is viewed solely as a precondition to charges for care alleged to be not covered by Medicare.

In our view both the legality and wisdom of this policy is subject to grave doubt. The protections in the regulation, and more, are needed for all beneficiaries. To maintain that they are triggered solely by a hospital's overt statement that it will seek personal payments from the beneficiary (especially since that "statement" is implicit in a hospital's statement that coverage is no longer needed or available) is downright silly. Moreover, it has created an unintended coverage anomaly. Since the notice is said to be a prerequisite to charges, if no notice is given, a beneficiary could technically remain in the hospital—after everyone agrees the stay was no longer necessary—free of charge.

While this anomaly illustrates defects in HCFA's policy, in fact beneficiaries are as unaware of this "right" as any other. In some individual cases in which we have been involved, however, it has allowed advocates or relatives faced with questionable and precipitous hospital-initiated discharges to insist on notice rights and/or extensions of stays. In each of these cases, as best as we can tell the hospitals always "reconsidered" their judgment that the beneficiary had to be promptly discharged.

The intervention of informed advocates or relatives in these situations clearly makes a difference. Such assistance has, however, been available in only a miniscule percentage of cases because few people are aware of these rights and law and policy fails to promote that awareness.

POST-DISCHARGE PROBLEMS

There are other problems which confront beneficiaries after their hospital discharge which, though not within the scope of this testimony, are related and important.

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[16] These reviews are triggered only where the readmission is to the same hospital. If a person is readmitted more than seven days later, or to other facility, review is not even triggered. Such monitoring, however useful for sentinel purposes, by definition occurs well after the fact.

[17] See, e.g., 49 Fed. Reg. 281-88 (Jan. 3, 1984); and 48 Fed. Reg. 39806 (Sept. 1, 1983).

[18] See 49 Fed. Reg. 234 (Jan. 3, 1984).

[19] PRO's are authorized to grant an additional two days of coverage—technically known as "grace days"—to accommodate discharge planning. See 42 U.S.C. 1320c-3(a)(2)(B); 42 C.F.R. 466.70(d). HCFA has ruled that the granting of grace days is strictly discretionary on the part of the PRO. See 50 Fed. Reg. 15367 (Apr. 17, 1985).

First, if beneficiaries require a level of post-hospital care other than skilled nursing facility care (e.g., home health services or "intermediate" care nursing facility services), they can be discharged from the hospital regardless of whether such care is available. Second, Medicare's coverage policies for SNF and home health care have been unduly restrictive, and deny adequate post-hospital care to many.

These problems, and the problem of the undersupply of these services for beneficiaries, are exacerbated by inadequacies in discharge planning obligations. Action to remedy these several problems would be extremely important.

SOME SUGGESTIONS FOR REFORM

(1) Hospitals should be required to give notices (of this type prescribed by 42 C.F.R. 412.42(c)) whenever they seek to discharge a beneficiary.

Such notices would help clarify coverage rights, document what the hospital is in fact doing, and alert beneficiaries to appeal rights. The forms for such notices have already been issued in HCFA's PRO Manual, and hospitals had long been required (prior to PPS) to give written notices to beneficiaries when the hospitals believed Medicare coverage had expired. The aggregate number of notices would clearly increase; however they would reflect a very small portion of the papers hospitals already issue to or for beneficiaries (e.g., bills, admission agreements, Medicare claims, charts, etc.).

The provision of notices in all these cases will have benefits beyond increasing beneficiary awareness of their rights. It would also produce a valuable data base from which Congress, DHHS, the PROs and the public would be more accurately informed about how the DRG system is actually operating.

(2) The appeal rights set forth in 42 C.F.R. 412.42(c)—and the related PRO regulations—should be improved.

(a) Beneficiaries should be entitled to some form of hearing—and decision—on continued coverage, within two days of the hospital notice.

Under present PRO regulations, beneficiaries who remain in the hospital can obtain "expedited reconsiderations" of hospital initiated discharge decisions within three working days of a written request. See 42 C.F.R. 473.32(a)(1) While is pace is a considerable improvement over the old law, the beneficiary still must incur 2–5 days of possible hospital charges to obtain the review. Requiring the review to be held and decided during the period in which the beneficiary is exempt from charges removes that disincentive to the exercise of legitimate appeal rights.

(b) Beneficiaries need more ready access to the PRO.

Under present policy, PRO concurrences in hospital discharge decisions are done by phone, without beneficiary reconsideration requests are processed in writing. The beneficiary (or representative) should be able to initiate the request by phone, or by personal communication to a hospial-based person, in order to expedite the process.

(c) DHHS should consult with beneficiary advocates and organizations as to whether changes in the form of the notice would be appropriate.

(d) PRO's should be required in all cases to promptly review a hospital's discharge decision.

Even if patients are informed of their right to appeal, (as per recommendation #1) a requirement that the PRO must concur on every hospital initiated discharge (even when the physician concurs) would provide an extra protection for beneficiaries and help doctors to resist pressure that hospitals sometimes exert on them to discharge patients.

At present, the PRO's concurrence is required (assuming 42 C.F.R. 412.42(c) otherwise applies) only where the beneficiary's attending physician refuses to concur with the hospital decision.

(3) PRO monitoring of hospital discharge practices must be improved.

Based on reports of advocates, it seems clear that PRO performance of their review activities is quite mixed. Some PRO's have reportedly been uncertain as to their responsibilities under 42 C.F.R. 412.42(c) in particular, and beneficiary-initiated reconsiderations in general. HCFA should promptly issue more detailed guidelines, after opportunity for public comment, governing PRO processing of expedited and regular reconsiderations. In addition, satisfactory PRO conduct of these obligations should be made a specific condition of their contract. HCFA—or, perhaps, the "Super Pro"—should also maintain a toll-free number to receive beneficiary complaints about PRO performance.

(4) Steps should be taken to educate Medicare beneficiaries about their coverage and appeal rights.

If beneficiaries are fully informed of their coverage rights, they will be better able to assert their rights and/or seek appropriate assistance. These educational efforts should take at least three forms: (1) support for the educational activities already being undertaken by organizations such as the American Association of Retired Persons; (2) increased creation and dissemination of informational flyers by DHHS; and (3) requiring hospitals to give informative brochures to beneficiaries around the time of admission. The PRO in Minnesota, for example, is arranging the use of such forms. HCFA has specifically refused to require that hospitalized beneficiaries be given such brochures, see, e.g., 50 Fed. Reg. 15365 (Apr. 17, 1985).

(5) Steps should be taken to better inform hospital employees, and doctors, about Medicare coverage rules.

Whether through design or ignorance, many hospital administrators and employees communicate improper interpretation of Medicare coverage rules to patients and others. Similarly, many doctors—who are important protectors of beneficiaries' coverage rights—are inadequately informed.

Requirements for staff education on PPS coverage rules should be strengthened, perhaps, for example, by being made a specific standard of the Medicare "Conditions of Participation" for hospitals. Communication of improper coverage rules could be made specific grounds for imposition of PRO sanctions such as denial of reimbursement in whole of part. HCFA should also instruct its Medicare Carriers to include conspicuous notices on point in the newsletters they periodically send to doctors.

(6) The Committee staff recommendation to expand advocacy assistance through the use of Ombudsment should be tested.

We support proposals to provide advocacy assistance to beneficiaries, to help them assert their rights regarding both hospitalization and post-hospitalization coverage under Medicare. Use of local Ombudsmen for this purpose sounds promising; however, we are concerned that the persons who would provide these services be highly trained and reasonably knowledgeable about medical coverage issues. Increased use of legal services programs and/or specialized Medicare Advocacy projects (such as Connecticut's "L.A.M.P." and L.A.'s Medicare Advocacy Project) for this purpose would also be valuable.

DHHS could be instructed to promptly establish several pilot projects to test the feasibility of these approaches, including coordination of different advocacy approaches.

These recommendations will not cure all the ills which this Committee has observed in the DRG system. In addition to post-discharge problems, issues of severity-of-illness distinctions in the DRG's HCFA's failure to provide added reimbursements for "disporportionate share" hospitals, and problems in the availability of SNF and home health care are all important areas not addressed by these comments and proposals.

But the topics here are important, and the reforms suggested will provide important health and protections for vast numbers of vulnerable people—remedies which other kinds of issues referred to really do not address. We support your concern in scrutinizing problem areas in the DRG system, and thank you for soliciting our view.

Chairman HEINZ. Dr. Hawes.

Dr. HAWES. Thank you, Mr. Chairman.

STATEMENT OF DR. CATHERINE HAWES, POLICY ANALYST, RESEARCH TRIANGLE INSTITUTE, TRIANGLE PARK, NC

I am here today to talk about what happens to patients once they are discharged from hospitals and the impact that PPS may be having on the long-term care system in general.

Unfortunately, there is very little systematic evidence about the impact of Medicare's prospective payment system, but what I hear from providers suggests that the impact of extends beyond the hospitals to what there is of the long-term care system.

Providers say that patients seeking home health and nursing home care are sicker and more in need of skilled nursing procedures and rehabilitative care.

Further, the influx of Medicare patients discharged from hospitals "quicker and sicker" may be shifting other patients out of nursing homes and into board and care facilities. Thus, PPS is having an impact that reverberates throughout the health care system, but which is not being evaluated.

Identifying the impact of PPS is difficult, because it is not the only change underway in the system. State reimbursement policies, attempts to control the supply and utilization of nursing home beds, and shifts in regulatory policy are also critical elements undergoing change.

In addition, the structure of the industry itself is in flux, with the growth of the proprietary sector and the corporatization of hospitals, nursing homes, residential care facilities, and home health agencies.

Not all of these changes will have a similar impact, but the complexity and simultaneity of these changes ought to raise the level of our concern about quality of care.

If I may digress for a moment from my prepared testimony, I would like to respond to HCFA's suggestion that what they viewed as an "insignificant" increase in SNF and home health utilization is evidence that there is not a problem in hospital discharges and quality of care received by the elderly. What HCFA suggests is that this proves the elderly are not being discharged "Sicker and quicker." Offhand, I can think of six or seven reasons that have nothing to do with the appropriateness of discharge that could explain why you do not see even more dramatic increases in nursing home and home health utilization.

One is that many States have no skilled nursing facilities. In Oklahoma, for instance, there are virtually no SNF's, as is true for several other States, and there is substantial empirical evidence on this. In addition, I have anecdotal evidence on the unavailability of skilled nursing care. Hospitals in Mississippi tell me that they cannot find a skilled nursing facility to take someone who needs tube feeding or respiratory therapy and that they send such patients to nursing homes in Louisiana and Arkansas.

So these are one set of reasons that we are not seeing even more significant increases in SNF utilization. Another reason is that nursing homes nationwide have very high occupancy rates. Areas of New Mexico and Texas do not, but nearly everywhere else, we are looking at 95 to 98 percent occupancy. When someone has 2 days to plan for a discharge from a hospital, they may have real difficulty in finding a good nursing home placement.

Third—and this is anecdotal—SNF's will not accept patients with very highly skilled nursing care needs because they do not have the staff to properly respond to their care needs.

Fourth, there is the issue of eligibility determinations. Providers say that they are afraid of retroactive denials by Medicare and are reluctant to accept Medicare patients in many instances.

Fifth, discrimination in favor of private-pay patients and against Medicare and Medicaid is a well-documented empirical fact, and that can also explain lower utilization of Medicare's SNF benefit.

Sixth, there are waiting lists. There are waiting lists of up to 2 years, even 3 years, for nursing homes, and 6 to 7 months, in my community, for home health.

In summary, elderly people discharged from hospitals may not be getting the services they need, and that may be the best explanation for why you are not seeing them go into nursing homes and home health agencies; they cannot find the facilities and other long-term care providers that will provide needed services. And I do not think that current evaluations by HCFA address those issues.

Chairman **Heinz**. May I just interrupt you there? That is an interesting point. Is there any analysis of what discharge planners think ought to happen to the patients versus what does happen to the patients? Let us assume that the discharge planners are professional, they are competent, they take their work seriously. Is anybody looking at what they think should be done versus what actually is achievable?

Dr. **Hawes**. Other people may be better prepared to respond. I do not know of any studies of that type. At Research Triangle Institute, we are currently planning a study that does look at acute care discharge. It is part of an evaluation of another program, and it may help answer that question. To my knowledge, there is not such a study. Other people may know.

Chairman **Heinz**. Does anybody else know?

[No response.]

Chairman **Heinz**. I am sorry to interrupt. Please proceed.

Dr. **Hawes**. I think in general there has not been funding of empirical studies to examine the effects of PPS beyond the doors of the hospital, to what happens in long-term care settings or what does not.

I think there is substantial reason for concern about quality of care among long-term care providers and their ability to respond to changing more acute care needs among the elderly. In nursing homes, it is critical, because 20 percent of the elderly will require such care at some time in their lives. A second reason for concern is that despite considerable progress, quality continues to be a serious problem.

I have just spent 2½ years on an Institute of Medicine committee looking at nursing home regulations, and I cannot think of any member of the committee that would assert with any confidence that the current regulatory system assures acceptable quality of care in the Nation's nursing homes.

A third reason I am concerned is because studies suggest that some attempts to constrain long-term care costs give providers incentives to reduce spending on staff, on social services, on food—that is, on areas that directly affect the quality of patients' lives. And when I hear HCFA assert in its testimony that prospective payment is going to lead to better quality review, I find that interesting and look forward to the achievement of that goal.

A fourth reason for concern about the quality of long-term care is the increasingly debilitated condition of individuals entering nursing homes. Given these causes for concern, I would like to make three points before I offer some recommendations for reform.

One is that Government regulation is not a failure. It has been responsible for substantial improvements in quality; however, further reforms are essential for assuring acceptable quality of care—in standards, in the inspection process, and in the enforcement of nursing home regulations.

Second, market forces can also foster improvements in quality. However, this requires empowerment of consumers, their families and advocates. Elevating patients' rights to a condition of participation, ensuring patients' access to legal representation, and strengthening ombudsman programs for nursing homes and board and care facilities are essential elements for enhancing market forces.

And the third point I will make, and I will submit the rest in written testimony, is that improvements in quality of long-term care can be achieved without substantial cost increases.

Thank you, Mr. Chairman.

Chairman Heinz. Thank you very much, Dr. Hawes.

[The prepared statement of Dr. Hawes follows:]

PREPARED STATEMENT OF CATHERINE HAWES, PH.D.

Mr. Chairman and Members of the U.S. Senate Special Committee on Aging, I apprecite the opportunity to discuss the issue of Medicare's Prospective Payment System and it's effect on quality of care.[1]

Unfortunately, there is relatively little empiricle evidence about the effects of PPS, but anecdotal evidence suggests that its impact extends beyond the hospitals to what there is of a long term care "system". Around the country, providers argue that patients seeking admission to nursing homes are sicker and more in need of skilled nursing and rehabilitative care. The same is true for home health agencies. Further, as testimony at one of your prior hearings suggests, the influx of Medicare patients discharged from hospitals "sooner and sicker" may be shifting some other nursing home patients into board and care facilities. Thus, the PPS system in hospitals is having an impact that reverberates throughout the health care system.

PPS is not the only change underway in the health care system. The aging of the population, changes in federal and state reimbursement policies, attempts to control the supply and utilization of nursing home beds, and shifts in regulatory policy are also critical elements of the system undergoing change. Further, the structure of the health care industry itself is in flux, with the growth of the proprietary sector and the corporatization of hospitals, nursing homes, residential care facilities, and home health agencies. Not all of these changes will have a similar impact on the quality of health care available and provided to older Americans, but the complexity and the simultaneity of these changes ought to raise the level of our concern about quality.

Concern about quality of care and quality of life for individuals requiring nursing home care arises from four primary factors. First, the issue is critical because 20 percent of the elderly will require such care, and the group most at risk of needing institutional care—the very old—is the fastest growing segment of the population.

A second reason for concern is that despite considerable progress, quality of care continues to be a serious problem. Clearly many nursing homes provide excellent care. It is this fact that makes serious sub-standard facilities and poor care in adequate facilities both unacceptable and unnecessary. Yet while most nursing homes are reported as in substantial compliance with federal standards and provide generally adequate care, serious problems persist even in average facilities. Overuse of psychotropic drugs, misadministration of medications, excessive use of physical restraints, inadequate physician care, inattention to resident's psycho-social needs, inadequate or inappropriate food and food service, the failure to provide needed therapys, and inattention to restorative care or that which minimizes functional decline, are continually cited as relatively common problems in nursing homes.

A third reason for concern is the increasing pressure at the state and federal levels to contain expenditures on long term care. Unfortunately there is a potential conflict between some kinds of cost containment policies and improvements in quality. Some studies suggest that in some cases nursing homes respond to reimbursement by reducing expenditures on nursing staff, activities, social services, and food—areas that most directly affect the quality of patient's care and lives. The concern raised by these conceptual and empiricle analyses make improved quality assurance even more essential.

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[1] The views expressed in this statement are solely mine and do not in any way represent the views of Research Triangle Institute, of any agency for which I am conducting research, or the Institute of Medicine's Committee on Nursing Home Regulation.

A fourth reason for concern about quality is the increasingly debilitated condition of individuals entering nursing homes. Let us dispell once and for all the myth that the elderly are in nursing homes because they have been abandoned by their families. They are there because they have serious multiple illnesses and disabilities. Within the last decade, patients admitted to nursing homes have been older and suffered from more chronic diseases and functional disabilities. As I have noted, the trend toward more accute health care needs is likely to escalate because of PPS. This increasingly debilitated condition of residents is of particular concern because so many also suffer from mental impairments, such as depression, confusion, and chronic senile dementia. Such vulnerable individuals are at particular risk if poor care is provided, and they are ill-equipped to assert and protect their interest on a daily basis.

Before I go on to discuss some specific ways long term care quality might be improved, I would like to set out three basic tenets: 1) Government regulation is not a failure. It has been responsible for substantial improvements in long term care quality, and it is essential for improving and assuring such quality for the elderly; 2) Government regulation cannot do everything. Market forces, too, can foster improvements in quality—if consumers, their families and their advocates are empowered; 3) Improvements in quality of care can be achieved without substantial cost increases.

I believe the entire long term care regulatory system for assuring quality needs systematic reform, with a more comprehensive, coherent approach to retionalizing reforms and standards of care, inspection proceedures, and the enforcement process. Such reforms might include attention to the following:

First, each patient discharged from the hospital ought to receive a comprehensive needs assessment. This assessment would at a minimum identify the patient's physical, functional (in terms of activities of daily living), and mental-emotional status. This assessment would form the basis for determination of the individual's care needs and the appropriate services and setting after discharge. Further, that assessment would form the basis for the individuals care plan to be developed by the provider of long term care services when such services are indicated. Finally, the assessment and resulting care plan forms the basis for evaluating the quality of care the individual receives after hospital discharge and for determining the effect of PPS quality of care.

In addition, there are at least two areas in federal certification standards that relate to facility capacity that ought to be examined more closely: (1) the current distinction in standards between skilled norsing facilities (SNFs) and intermediate care facilities (ICFs); and 2) current staffing patterns in nursing homes.

The current federal certification standards are predicated on the assumption that SNFs and ICFs serve patients or residents with differing care needs. In practice, this distinction is no longer meaningful for a variety of reasons. First, the certification status of nursing homes as either SNF or ICF has more to do with Medicare and Medicaid eligibility criteria and levels of Medicaid reimbursement that to any reasonable criteria based on the characteristics of patients in those facilities or their actual care needs. The reality is that these definitions of SNF and ICF do not separate the nation's nursing homes or its patients into two distinct types. Rather they describe a broad range of facilities that in practice serve different combinations of patients with diverse physical health problems, mental disabilities, and functional impairments.

A second problem with the nominal distinction between SNF and ICF is that it fails to capture the reality of the very complex care needs of nearly all nursing home residents. In both types of facilities, patients need professional medical care, skilled nursing care or skilled supervision of care, attention to rehabilitative care that restores or minimizes the decline of functional abilities, attention to mental health needs, and attention to quality of life and personal rights.

The assumption has often been made that ICF patients need less care, in fact, there is substantial evidence that many of these patients, particularly those with severe mental and functional impairments, require more "hands-on" care assistance, and supervision—and thus more staff time—than the typical "skilled care" patient. Thus, the staffing standards and reimbursement patterns that are associated with the distinction between SNF and ICF may no longer be useful or meaningful, given the increased age, illness, and multiple disabilities we are seeing in the nursing home population.

In the area of staffing we ought to consider at least three elements. First ICFs are not required to have an R.N. on duty at any time. They may meet standards with one L.P.N. or L.V.N. on one shift and with aids providing all care unsupervised by any nurse for up to 16 hours per day. While such standards for nursing staff can be regarded as minimal, there are no specific federal training requirements concerning the numbers, qualifications, or pre-employment training of aids, who provide between 80 and 90 percent of all care. Finally, for rehabilitative therapists, the picture is even more troubled. The practical reality is that the amount of rehabilitative care provided to nursing home patients is negligible. A 1983 analysis of staffing patterns shows that in 68.2 percent of all Medicare and/or Medicaid certified facilities, there are no rehabilitative therapists.

Mr. Chairman, these are just a few of the changes I would recommend in our health care system to improve quality of care. I would ask that my full statement be included in the record. I would be happy to answer any questions you might have.

Chairman HEINZ. Dr. Eggert.

STATEMENT OF DR. GERALD EGGERT, EXECUTIVE DIRECTOR, MONROE COUNTY LONG-TERM CARE PROGRAM, ROCHESTER, NY

Dr. EGGERT. Thank you, Mr. Chairman.

My name is Gerald Eggert. I am the executive director of the Monroe County Long-Term Care Program in Rochester, NY. And what I would like to do is describe a demonstration program that has been funded by HCFA over the last several years that attempts to do two things simultaneously. We attempt to try to reduce the use of hospital care by the elderly, and at the same time we try to increase the use of home health and nursing home use in an adequate, appropriate and safe way.

The rationale behind the Monroe County Long-Term Care Program is that if earlier hospital discharges are going to occur, and our Federal health care programs are going to encourage less hospital care, that change should be accompanied by a more adequate provision of post-acute care. Only in this way can change occur without putting in jeopardy the quality of care patients receive.

The ACCESS experience has demonstrated that we can safely reduce hospital length of stay by providing adequate nursing home and home health services, proving that quality of care is fully compatible with cost containment when done right.

The major mechanisms for achieving these objectives have been a comprehensive assessment of the patients' needs, case management, and waivers of traditional Medicare eligibility requirements for post-acute care.

As the population ages, and as the prospective payment system acts to discharge sicker patients into the long-term care system, a new class of patients is developing. This new class is neither acute nor skilled nor chronic, but has characteristics of all three. These are the high-cost, high-risk patients whose expenses are catastrophic to themselves, to Medicare and to Medicaid, and to other third party payors.

In Medicare, 7 percent of all beneficiaries use 60 percent of services; in Medicaid, 10 percent of recipients use 75 percent of services. The vast majority of these Medicaid high-cost users are also Medicare-eligible. For lack of a better term, we have called this group the "catastrophic" group. These are the heaviest users of hospitals, nursing homes, and home health services. This is the group that the ACCESS: Medicare Program has identified as most in need of post-acute services as a way of reducing acute care use.

We feel that adequate post-acute home health and nursing home services will act as a deterrent toward unnecessary hospital readmissions by this very frail group. Our goal over the long term is to determine the extent to which adequate home health and nursing home services will decrease the frequency of hospital readmissions for the most frail elderly.

This population needs a modified post-acute benefit to allow them to safetly and quickly move from acute to post-acute settings

This is an interesting subscript. The ACCESS: Medicare Program came out of a long tradition in Monroe County, Rochester, of looking at the way we look at hospital beds. We have one of the lowest proportions of hospital beds per 1,000 in the country, about 3.4 per 1,000. In 1964, the Blue Cross plan developed a home health benefit that was then incorporated by Medicare as its home health benefit under the new Medicare Program.

Most recently, we have been looking at ways to organize and coordinate a system of care that identifies and targets the most frail elderly. We feel that over the long term, the only way we can reduce the use of hospitals is to try to identify those most at risk of inappropriate use, or perhaps repeated admissions, and then manage a home health and nursing home system, with adequate reimbursement at the home health and nursing home levels. This provides the best way to reduce overall costs in the long term.

We have a strategy where we already have more nursing home beds per 1,000 than any other county in New York State, and we have developed a strategy to increase the use of home health care. When we first started in 1975, for every 14 people in the nursing home, there was one person at home receiving reimbursed services. The ratio is now, for every one person at home, there are only three people in a nursing home. So what we have done is to introduce better balance in the system.

One of the key components to do this is to change the definition that Medicare uses for skilled care. We have a waiver of the definition of skilled care that allows us to provide nursing home services to people who have multiple unskilled needs that would have been defined as chronic, and currently is throughout most of the country, but these are the people who are most at risk of repeated hospital admissions.

We also have waivers of the definition under the home health requirement, for the homebound requirement, and the intermittent care requirement, permitting us to put up to 16 to 18 hours of care a day in a person's home. We think this is extremely important in reducing readmissions to hospitals of people who are very frail and who are discharged earlier. I have data in the testimony that shows that we have reduced the number of hospital days dramatically. I think that a viable strategy for Medicare to take as they look at ways to try to reform the program is to increase access to both home health as well as nursing homes, to redesign the benefits to take advantage of this fact, and to recognize that we are dealing with a much different population that is being discharged from hospitals than was the case 20 years ago and to try to tie the system together with a case management model in a coordinated way.

Now, a lot of the things we have been doing the last 4 or 5 years were contained in some of your legislation, namely, the Health Care Coordination Act. I think one of the key things that we have done is we have increased the certainty to sub-acute providers that they will be paid.

One of the major problems of the current Medicare Program is that this issue of disallowing payment to providers who accept Medicare people into nursing homes, we prior-approve payment—we approve medical necessity as well as payment approval for all nursing homes and home health agencies, so they know they are going to be paid. With this kind of a quid pro quo, we find that nursing homes as well as home health agencies are willing to admit people earlier and provide adequate care.

[The prepared statement of Dr. Eggert follows:]

PREPARED STATEMENT OF GERALD M. EGGERT, PH.D.

Senator Heinz, I am Gerald Eggert, executive director of the Monroe County Long Term Care Program in Rochester, N.Y. I appreciate the opportunity to be here today. I believe the ACCESS: Medicare program, operated under the Monroe County Long Term Care Program, is a viable solution to the problems of access and quality in post-acute care that this Committee has identified.

The rationale behind this program is that, if earlier hospital discharges are going to occur and our federal health care programs are going to encourage less hospital use, that change should be accompanied by more adequate provision of post-acute-care. Only in this way can this change occur without putting in jeopardy that quality of care patients receive.

The ACCESS experience has demonstrated that we can safely reduce length of stay by providing adequate nursing home and home health services, proving that quality of care is fully compatible with cost-containment, when done right.

The major mechanisms for accomplishing this objective have been comprehensive assessment of patient's needs—a key component of hospital discharge planning and is available to all Medicare and Medicaid patients in Monroe County who may need home health and/or nursing home services; case management—which develops care plans and arranges services for those persons whose assessments have indicated a need for sub-acute health care services; and waivers of traditional Medicare eligibility requirements for post-acute care.

As the population ages and as the prospective payment system acts to discharge sicker patients into the long term care system, a new class of patients is developing. This new class is neither "acute" nor "skilled" nor "chronic," but has characteristics of all three. These are the high cost, high risk patients whose catastrophic to themselves to Medicare and Medicaid and to other third party payors. In Medicare, 7 percent of all beneficiaries use 60 percent of the service dollars available under the program. In Medicaid, 10 percent of all beneficiaries use 75 percent of all services.

The vast majority of these Medicaid high cost users are also Medicare eligible. For lack of a better term, we have called this group the "catastrophic" group—those who are the heaviest users of hospitals, nursing homes, and home health services. This is the group the ACCESS: Medicare program has identified as most in need of post-acute services as a way of reducing acute care needs.

We feel that post-acute health and nursing homes services will act as a deterrent toward unnecessary hospital readmissions by this very frail group. Our goal over the long term is determine the rate at which adequate home health and nursing home services will decrease the frequency of hospital readmissions for the frailest elderly.

This population needs a modified post-acute benefit to allow them to safely and quickly move from acute to post-acute settings. In order to ensure that a continuum of care exists for these patients, we must establish a smoother transition from acute to post-acute settings, redefine the Medicare home care and skilled nursing care benefit, and incorporate the concept of case management much more fully into the continuum of care. The ACCESS: Medicare benefit package serves as just such a transition.

The Monroe County Long Term Care Program, Inc. was created in 1975 as a cooperative venture of federal, state, and local governments, health care providers, consumers, and business interests. The concept of this program was based on the Medicare Long Term Care Act, introduced by Representative Barber Conable, a long time Congressman from Rochester. Monroe County has had a history of restraining the growth of health care expenditures by both limiting the supply of hospital beds as well as developing our own hospital-based prospective payment system that has been operational for serveral years. The ACCESS: Medicare program has a unique set of Medicare Section 222 waivers that provide post-acute home health and skilled nursing facility benefits to the Medicare population. The purpose of the ACCESS: Medicare program is to minimize the growth of institutional expenditures through the substitution of less expensive home care and nursing home services for more costly acute hospital care.

The ACCESS: Medicare program incorporates into a rational, cost-effective health care system for the frail elderly a number of the recommendations this Committee has made.

First, the greatest problem Medicare patients face today is the absense of a uniform way of evaluating their post-acute care needs. Our program assesses a patient's care needs before hospital discharge. This assessment enables a patient's physician, a nurse, and a social worker to evaluate the patients needs according to his or her physical, functional, and mental conditions at the time of hospital discharge.

Second, there is no coordination of care available to most patients once they leave the hospital. To address this problem, the ACCESS: Medicare program uses case management to ensure that the patient is not "lost" as he makes his way through the health care system, that he actually receives the care he needs, and that his care plan changes to reflect his changing needs.

Third, many nursing home and home health care providers are reluctant to admit Medicare patients for fear that the admission will be denied. We solve this problem by using case management to prior-approve Medicare and Medicaid skilled nursing and home health benefits for patients who would otherwise remain in hospitals inappropriately or be discharged without appropriate support services available to them out of the hospital. In this way, providers are sure that admissions to their facilities are covered by Medicare.

Fourth, patients are often denied post-hospital care because of traditional rules that can prove to be too stringent in light of today's sicker post-acute population. To meet this problem, the ACCESS: Medicare program has a waiver of the definition of skilled care, enabling us to cover individuals needing multiple unskilled services in addtion to those needing daily skilled management, a waiver of the homebound and intermittent requirements under the Medicare home care benefit, and a waiver of the three day rule that requires Medicare to pay for skilled nursing care only after a patient has been in the hospital for at least three days. We also approve payment for services under both Medicare and Medicaid for the dually eligible population, a concept put forth legislatively by Senator Heinz earlier this year.

The program also has developed a "Sudden Decline" benefit that reimburses nursing homes and physicians for evaluation and care of patients whose conditions have temporarily worsened. This benefit prevents the admission to hospitals of nursing home patients who can be appropriately and safely cared for less expensively in nursing homes rather than in hospitals.

Each of these strategies is designed to reduce hospital admissions and ensure quality care for the high risk, high cost Medicare populations in a cost-effective way.

In 1984, reduced hospital use by Medicare beneficiaries more than paid for the increased costs of providing adquate home health and nursing home care under this program. After subtracting waiver and case management expenses, Medicare expenditures in Monroe County appear to have been reduced by $13 million from 1982, the year before the ACCESS: Medicare program began, to 1984, based on our own aggregate data. The number of hospital days utilized by skilled nursing certifiable skilled level residents of Monroe County eligible for both Medicare and Medicaid during this same time period fell from 103,000 to 44,000. The average length of stay for this group declined from 85 days to 45 days, and admissions to hospitals declined 19 percent.

Skilled level residents of Monroe County who were eligible for Medicare, but who normally would have to pay for nursing home services out-of-pocket (the so-called Medicare/private pay population) used only 55,000 hospital days in 1985 as compared to an estimated 102,000 in 1982. The average length of stay for this group declined from 58 days to 31. The reduced hospitalization among the Medicare/private pay population is believed to be attributable to the expanded definition of "skilled care" which allows Medicare to pay for home health and nursing home services individuals would ordinarily pay for out-of-pocket.

At the same time, there were no reports that patients were being discharged from hospitals without appropriate post-acute care.

In this way, the ACCESS: Medicare waiver tightens the linkage between early hospital discharge and the provision of appropriate sub-acute services.

Mr. Chairman, the problems that today's frailest elderly face in getting the post-acute care they need have been well-demonstrated by this Committee. The incentives of the PPS, which serve to discharge patients from hospitals sooner and sicker, combined with traditional Medicare eligibility requirements have put unnecessary barriers between Medicare patients and the care they need.

I feel very strongly that, under the ACCESS: Medicare program we have been able to provide solutions to these problems by 1) increasing post-acute Medicare services to patients in need, 2) providing the types of services most in need, 3) ensuring quality of care throughout the continuum of care, 4) ensuring that a continuum of care exists for patients in need, and 5) doing all this in a cost-effective way.

In order to make the prospective payment system function efficiently over the long run, we need to take some of the savings achieved through reduced use of hospitals and use them to provide more adequate nursing home and home health benefits. In this way, the fiscal victories the DRGs have achieved in the last year or two may be sustained over the coming years.

Mr. Chairman, I ask that a short description of the program's early history be inserted into the hearing record.

HISTORY OF THE ACCESS: MEDICARE PROGRAM

ACCESS was created in 1975 as a Medicaid Section 1115 demonstration program. Fully operational by the summer of 1978, ACCESS eventually had Medicaid 1115 waivers for friendly visiting, heavy chore, respite care, housing assistance, moving assistance, social transportation, housing improvement, and adult foster family care. While the evidence is not conclusive because a randomized experimental design utilizing a control group was not employed, the provision of assessment and case management services coupled with the availability of additional in-home community based services appears to have resulted in a lesser increase in Medicaid expenditures than would have been anticipated. In the early ACCESS experience (1978–80), the rate of growth of Medicaid expenditures in Monroe County (19 percent) was considerably less than the rate of increase in six comparison counties in New York State (33 percent). For 1983 and 1984, after the implementation of the Medicare 222 waivers, the annual growth rate of Medicaid expenditures in Monroe county fell to less than 6 percent, as compared to an average rate of increase of 18 percent for the seven previous years.

Chairman **Heinz**. Your point about the uncertainty of payment for home health care providers was brought home to me the other day when I was visiting with my home health care association in Pennsylvania. Each provides explained how it just gets more and more difficult to get reimbursed, how it is getting slower and slower to receive reimbursement, and how they in effect are delivering a higher and higher burden of what, for all practical purposes is uncompensated care. They may get compensated sometime in the future, but it is a long time, and it is an uncertain future.

It is very true. One would be hardput not to reach the conclusion that there is a conscious strategy being followed by the Health Care Financing Administration to do exactly that. I see a lot of heads nodding up and down.

You have all provided very valuable insights and recommendations, and I know that many of you abbreviated your testimony, and without objection, your entire testimony will be made a part of the record. I do have a few questions, though.

Dr. Malmud, you have provided an eloquent justification for improving the DRG's so that they are more sensitive to the differing medical needs of individual patients. In your own experience as a clinician having to adjust to what is already a complicated system, is there a chance that the types of changes you advocate could render the system unworkable?

Dr. **Malmud**. No, I think that the changes would be workable. The coding system already exists for including severity of illness within the ICD-9 codes, and the system has to be changed. If we do not change the system, we will be closing our eyes to those who are Medicare recipients, and also penalizing those institutions that are continuing to deliver care to Medicare patients.

Chairman HEINZ. Now, what has been the impact of PPS generally on Temple University Hospital? Have you had to in any sense reduce the quality of care that you are delivering to Medicare patients?

Dr. MALMUD. I am not aware that we have reduced the quality of care presently. We are absorbing the loss, though, at the present time, and there is a serious question as to how long we can continue to absorb losses to the extent that we are.

We hear stories of other hospitals that have abbreviated lengths of stay. We have not done that at Temple. We have consciously kept patients to the point where we feel they are ready to be discharged to an aftercare facility or a skilled nursing facility, and this is frequently beyond the cost-effective day that the DRG's have established.

Chairman HEINZ. I gather that you think Dr. Horn's methodology would be useful and indeed, in a practical sense, looking at the chart,[1] Temple University Hospital may be one of those red lines below the zero axes there; is that right?

Dr. MALMUD. Exactly. If we were there, we would be No. 2 and No. 4, the ones with the most significant losses.

Chairman HEINZ. Let the record show that No. 2 and No. 4 are red lines reaching down, down, into the bowels of insolvency.

Dr. MALMUD. That is what we are threatened with. Ten million dollars a year is a lot of money for us, as our hospital budget is only slightly over $100 million a year.

Chairman HEINZ. It is a lot of money anywhere except in Washington, DC. [Laughter.]

Dr. Horn, those charts are exceedingly articulate representations of many of the points you made verbally in your testimony. Could you go over them, and just one more time, show how severity indices enhance the ability of DRGs to account for individual patient differences?

Dr. HORN. OK. Let us look at DRG-403. These are very sick patients from the disease they have. But as you see, there are two types of patients within this DRG. There are ones that have an operation—those are in the right cluster of four—and those that do not have an operation; those are in the left cluster of four. In this DRG, there is no attempt to take into account operating room procedure, and you can see that the average costs of those with an operating procedures are significantly higher than those without. Hence, those hospitals that treat more of those patients—and it is usually an oncology center that would have those patients—are going to be greatly underreimbursed for the type of care they are giving.

The other problem is the one of severity itself, which is color-coded, and it is very clear that those who are less severely ill, just the way Dr. Malmud described them, not having complications or other diseases, they are going to be severity level 1, the lower level; but then, severity level 2, as they begin to have more complications, and severity level 3, even further complications, and finally, the catastrophic patients, with severity level 4. You can see the dramatic differences in resource use, which again, a fixed value for a DRG would not take into account. And hence, those hospitals treating more of the less severely ill patients can be greatly overpaid, and those treating more of the more severely ill patients will be greatly underpaid.

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[1] Charts referred to are included in Dr. Horn's testimony.

Chairman HEINZ. Looking at what to the untrained observer, namely me, appears to be an anomaly, is that you have two blue bars for severity level 4, and as might be expected, where there has been a moderate OR procedure, the level 4 has the highest cost. But where there is not an operative procedure, level 4 is substantially below level 3 in terms of cost.

Dr. HORN. What happens there is all the deaths are in level 4. And I have not trimmed these data in any way. And what can happen is when those patients are so ill, so catastrophically ill——

Chairman HEINZ. They are so fargone that——

Dr. HORN [continuing]. That they decide not to treat them, and then their resources drop.

Chairman HEINZ. Operating would be just a risk to their already fragile health.

Dr. HORN. Right—which points out that hospitals are being careful in how they are using their resources; but when they have a chance to save those patients, then to take care of those catastrophic patients, the cost rises dramatically.

Chairman HEINZ. You have described a serious flaw in Medicare DRG's, that they do not properly account for multiple, chronic, disabling conditions that many older people have. Your work on a severity adjustment is obviously intriguing and extremely valuable. How practical is it for a severity adjustment such as we see over here to the right to be applied, in fact, to the DRG's, and can you really say that if we did it, it would be, as your third chart indicates, budget-neutral—or would there be costs associated with it?

Dr. HORN. I will answer the last question first. It can absolutely be budget-neutral. In fact, I think in the longer run, when we can look more carefully at resource use by severity level, we even will have the ability to be able to control costs better than we have at present. But we will still have a fair distribution so that the sicker patients will be justifiably reimbursed higher.

In terms of how practical it is, severity information can be obtained from an expanded ICD-9 CM codebook that incorporates severity criteria. This new codebook was developed under a grant from the Pew Memorial Trust in Philadelphia, and is based on a six-digit system. The first five digits are the same as the current disease condition labels in the present ICD-9 code used by all hospitals in the United States. The sixth digit, 1 to 4, tells how severe the disease is, using objective signs and symptoms, laboratory values, radiology findings, et cetera.

The new codebook, then, will be used to create an expanded discharge abstract data set, consisting of principal and secondary diagnosis labeled in six-digit codes and a rate of response to therapy variable such that a computer algorithm can put all this together to come up with the overall severity classification.

So that it is very feasible, and the hospitals that have been using this have found that it takes them no more time to collect that extra information, that is so beneficial.

Chairman HEINZ. I must say, as you read it, it sounded complicated. But I am delighted to know that the hospitals can——

Dr. HORN. Maybe I can make the point a little more easily. When a hospital determines a patient has, let us say, COPD, [chronic obstructive pulmonary disease] they have to look at the signs and symptoms of the patient to make that diagnosis. They now only look at the signs and symptoms and say, "Oh, that is chronic obstructive pulmonary disease."

What severity does is, after they have looked at those criteria, it records in the sixth digit how badly they have that chronic obstructive pulmonary disease. So they have looked at the information; they just have not recorded it to date. That is why the system can be applied to simply.

Chairman HEINZ. Very well.

Vita, I have a couple of other questions for you, but do you generally agree that what Dr. Horn and Dr. Malmud are advocating makes sense?

Ms. OSTRANDER. Yes, yes; very, very, much. This is an area we have discussed for the longest time, that we have got to begin to address those differences.

Chairman HEINZ. It is not the only answer to the problem, but I think it is a very essential, significant, important part of the answer.

I will be introducing legislation in the next few weeks that will address the issue of protecting quality in hospitals; it will address the discharge planning issues that have been raised; it will address the question of how we extend quality protections after discharge from the hospital, but a very central element of it is going to be the severity of illness adjustment in the DRG's.

Let me ask you, Vita, if I may, you travel incessantly around the United States. You hear an awful lot from your enormous membership. What are you hearing about DRG's? Are people out in the real world telling you their problems, or do the people inside the beltway from the Health Care Financing Agency have an accurate picture?

Ms. OSTRANDER. Your point is well taken. Yes, I do travel incessantly. And in that travel, in talking to membership, No. 1, they do not know what is happening out there. They come, and they will say, "We were told our days were up. We were not prepared to go home with this kind of a continuing seriousness of our illness. We do not have a family support system."

I have talked to aging directors who say to me that families are calling as well as beneficiaries. They are saying, things are happening that they just have never dreamt would happen to them.

And one of the areas particularly that we are getting more and more comments from the membership is the area of cataract surgery as an outpatient, which PRO's currently are not able to review. In many instances, they go home—I had a retired teacher the other day who came to me in a meeting. She had a walker. She said, "I had no one to go home to. There was no way the Agency could provide me services. The waiting list was too long."

Chairman **Heinz**. So, what you are hearing is very similar to what Dr. Hawes was suggesting as the reason that the HCFA information on the number of people being discharged into nursing homes and home health care settings was low, which is that there is no place to go.

Ms. **Ostrander**. Absolutely, there is no place to go. But there is also another factor, and it follows with what you heard them say, and that is that some of the long-term care institutions do not have adequately trained personnel to deal with the sicker patient. And in many instances, before they will commit a bed, they will call back a nurse on duty to find out the severity of the illness of the patient that is being discharged and make the decision on that basis.

There are some very real problems in what happens at that point.

But I would like to also answer something you asked Mr. Haddow——

Chairman **Heinz**. I am glad I am going to get some answers to some of my questions some of the time.

Ms. **Ostrander** [continuing]. What about the beneficiary as to their rights. And he said they are posted. But what no one is addressing is the condition or the frame of mind of the beneficiary when they are being admitted to the hospital. At that point, it is too late for them to know what their rights are. And I believe HCFA has a responsibility to move far more aggressively into that educational process.

Yes, AARP is doing a good bit. We expect the physician community as well as HCFA to assume that responsibility, and not at admission.

Chairman **Heinz**. That is a well-taken point, and I assume Judy Waxman would agree with that.

Ms. **Waxman**. Yes, I absolutely agree, but I would say and also at admission.

Chairman **Heinz**. Pardon me?

Ms. **Waxman**. Also at admission. There should be education at the time of admission to reinforce what people should have been told before they were ever admitted to a hospital.

Chairman **Heinz**. Yes, my sense is exactly that, that if you wait until the person is admitted to the hospital, and particularly somebody who is at level 3 or level 4, they are not walking into the hospital and saying, "Say, I think I am sick." It almost reminds me a little bit of the tombstone that says on it, "I told you I was sick."

You have got a lot of people for whom that information comes a little too late, because they are too ill.

Dr. Hawes, in your judgment, looking at the post-discharge issue, what are in fact the key elements to ensuring quality care for patients after they leave the hospital?

You mentioned that there has got to be someplace for them to go, where they can get health care. That is pretty fundamental. Anything else?

Dr. **Hawes**. I think there are several things. One is that before someone is discharged from a hospital, there ought to be a comprehensive, multidimensional needs assessment for that patient that would at a minimum identify physical, functional and mental and emotional needs, and his or her social and economic resources. That would be the basis for determining what is the appropriate discharge location, what is the appropriate discharge time, and what care and services that person needs. Such a needs assessment forms the basis for the PRO to evaluate whether or not it was an appropriate discharge and what quality of care the patient needed versus what he or she received. So that is one thing, to have a comprehensive needs assessment performed before patients are discharged from the hospital.

Second, we have got to pay attention to what the capability or capacity is of other long-term care providers—home health agencies, nursing homes, and board and care facilities to the degree that they are affected. And I would refer you, since we have heard about HCFA's information on quality of care in nursing homes, to a 1983 study by Systemetrics for the Assistant Secretary for Planning and Evaluation, which shows some interesting things about nursing home capacity at that point in time. Based on HCFA's own data, they estimate, 68 percent of all the nursing homes that are Medicare and Medicaid certified had no rehabilitative therapist on staff. This report also provides information on what the nursing staff levels are.

We are looking at a large number of facilities——

Chairman HEINZ. It implies that skilled nursing facilities are not very skilled.

Dr. HAWES. Well, skilled nursing facilities are often not capable of providing very skilled care. Moreover, many people are going into ICF's, because that is the only place available. Under current standards in an ICF you can operate without a single registered nurse on duty ever, and you can have aides with minimal training, providing care, unsupervised by an R.N. or an L.P.N., for up to 16 hours a day. Now, fortunately, there are not a vast number of facilities where there are no registered nurses, but there is a sufficient number for us to be concerned about those kinds of staffing levels, particularly given the increasingly debilitated condition of patients.

Chairman HEINZ. You mention in your testimony that you favor moving away from the current levels of care that currently determine nursing home reimbursement. I understand that the IOM may have also been looking at this problem. Could you tell us what sort of system you would put in its place instead?

Dr. HAWES. I can tell you what I would think, but I am sworn to silence on what the IOM committee thinks. We have not yet published the report, and it has not made it through the National Academy of Science review process.

My own feeling about the SNF/ICF distinction is that it is virtually meaningless. It is predicated on the idea that it describes two distinct types of facilities and two distinct types of patients. In actual reality, what you see is that both facilities serve patients with diverse physical, functional, and mental impairments. There are not two distinct kinds of patients; there are not two distinct kinds of facilities. I think the distinction still persists for eligibility reasons and for reimbursement reasons. States can pay ICF's a lower reimbursement rate than SNF's, and Medicare does not have to pay for ICF care at all. It does not bear any relationship to patient characteristics or to their care needs, or to the resources they may utilize in the nursing homes.

For instance, ICF patients who are, demented, incontinent, and functionally impaired will consume many more resources in terms of staff time than a skilled care patient who is, say, recovering from a hip fracture. So the current nominal distinction between SNF and ICF is unjustified both in terms of standards and in terms of reimbursement level. This is, I should say again, my own view and not necessarily that of the IOM.

Chairman HEINZ. That is very, very helpful.

Dr. Eggert, I understand that your program pools the funds available for long-term care under both the Medicare and Medicaid programs, in the way you mentioned, similar to that which would be mandated by my legislation, the Health Care Coordination Act.

Would you have any advice as to whether, if we move toward that kind of a system, the budget fears about such a measure of the Health Care Financing Administration are justified?

Dr. EGGERT. I guess the question of the budget fears is whether the home health and nursing home services would be add-ons, basically. It depends on to whom we give the services. The ACCESS Program tries to identify the high-risk people who are at most risk of repeated hospitalization, and it is for that group of people that it makes a lot of sense to have a beefed-up SNF and home health benefit. And then, we need to make sure that you can consolidate as much of the payment approval in a single agency. So we prior-approve both Medicare and Medicaid benefits.

It is interesting, to go back to your comment about certainty. One does not have to increase the amount of money you spend if you increase the certainty of paying it. In nursing homes, the bigger fight is over whether they get paid at all as opposed to the level of payment. It is worse for a nursing home to look at a 100-day stay for which they receive no reimbursement potentially than for which they might argue over $2 or $3 a day.

We have found that simply by increasing the Medicare rates up to 2, 3, 4, 5 percent more with our guaranteed reimbursement, that nursing homes are very willing to accept people who in the past, they would have been very hesitant to admit.

In addition, they are willing to change their staffing. I mean, form follows financing. If we are willing to pay for more adequate nursing home benefits, the nursing homes will do it; the same with home health. And I do not think that we have to do it at an increase in what Medicare expends, because I think over time, we are going to find that the DRG system is going to incur a readmission rate for very disabled people that in the past, might not have occurred. And it is these people whom we can afford to, and perhaps from a cost-effective point of view we should, provide a home health and nursing home benefit.

So I think the principles that you have in the legislation make a lot of sense, especially if we target the people who are most at risk of being repeatedly admitted to hospitals.

I think the key is the targeting issue. We do not have to enroll everyone in order to try to reduce expenditures, because with the

Lorenz Curve, or Paredo's Law, that about 20 percent of the people account for 80 percent of expenditures. What we need to do is try to find a way to identify and predict who these high-cost users are, and then enroll those people on a priority basis and a managed care system. That is what we have done, and I think if we can do that, we can not only provide better services, but we can also act in a cost-containing way.

Chairman HEINZ. Dr. Eggert, thank you very much.

You have been a marvelous panel of witnesses. You have given us insights into a number of what appears to me to be very sound methodologies for solving what, up until recently, at least insofar as HCFA is concerned, have proved to be intractable, unaddressable, even unknowable problems.

As they say, you may create a little heat when you shed a little light, and I think we have done both. But the result is that we have also, I think, created an environment where some good suggestions can come forward. Each of you has given us some very good and helpful suggestions.

I mentioned a moment ago that I will be introducing legislation. I hope that I can have the support of many members of this committee. We have had many of our members participate in this series of hearings on the effects of the prospective payment system on Medicare beneficiaries, in terms of admission, in terms of being in the hospital, in terms of being discharged, and in terms of what happens to them after the discharge.

My legislation is going to be reaching across-the-board, and my goal is to try and save the prospective payment system from some very serious flaws.

I am one of those people who instinctively tries to make a system that is in place as responsive and as good as we can make it. Probably the only thing worse than having a system that performs inadequately is just changing for the sake of change, and we would be well-advised to try and make the best of the prospective payment system at the earliest possible date; if we do not, we will get change for the sake of change, and my experience has been that that often leads to what can prove to be an even worse situation for all concerned.

I thank you all very much, Dr. Malmud from Pennsylvania; Dr. Horn from Johns Hopkins; Vita Ostrander, whose energy as leader of the ARRP is just extraordinary; Judy Waxman, who looks out for the consumers on a full-time basis; Dr. Hawes, who has some very good insights as to what is happening in the nursing homes and home health areas, and Dr. Eggert, likewise.

We thank all of you very much for your participation.

The hearing is adjourned.

[Whereupon, at 1:18 p.m., the committee was adjourned.]

STAFF REPORTS

IMPACT OF MEDICARE'S PROSPECTIVE PAYMENT SYSTEM ON THE QUALITY OF CARE RECEIVED BY MEDICARE BENEFICIARIES

Staff Report

Special Committee on Aging,
United States Senate
John Heinz, Chairman

September 26, 1985

Staff Report of the
United States Senate
Special Committee on Aging

IMPACT OF MEDICARE'S PROSPECTIVE PAYMENT SYSTEM ON THE QUALITY OF CARE RECEIVED BY MEDICARE BENEFICIARIES

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IMPACT OF MEDICARE'S PROSPECTIVE PAYMENT SYSTEM ON THE QUALITY OF CARE RECEIVED BY MEDICARE BENEFICIARIES

A Staff Report of the Senate Special Committee on Aging

EXECUTIVE SUMMARY

INTRODUCTION.

This report summarizes the findings of an investigation by Committee staff, conducted over a four month period. Staff visited and collected data from five Peer Review Organizations (PROs), and a number of community and university hospitals. The inquiry involved scores of interviews with Medicare beneficiaries, practicing physicians and nurses, university researchers, and personnel and managers from PROs, hospitals, Health Care Financing Administration (HCFA), and DHHS Office of Inspector General (OIG). In addition, Committee staff gathered and analyzed voluminous records obtained from these organizations and individuals.

Major findings of this inquiry to date are as follows:

WHAT IS THE PROBLEM?

PROBLEM #1: Seriously ill Medicare patients are inappropriately and prematurely discharged from hospitals.

PROBLEM #2: Hospital patients who live alone and are too sick to appeal hospital discharge decisions are without any protection under Medicare's Prospective Payment System (PPS).

PROBLEM #3: Many patients, especially the terminally ill and their families, are being given false and incomplete information on their rights of discharge appeal and on options for post-hospital care.

PROBLEM #4: Some hospitals have denied admission to patients with multiple serious conditions.

HOW EXTENSIVE ARE THESE PROBLEMS?

Existing Medicare data do not allow a precise answer to be given. There are, however, significant indications that these problems are more severe and widespread than current HCFA estimates, based upon the very limited information available from PROs, would indicate.

The Health Care Financing Administration has focused the PROs on a very narrow and incomplete set of quality issues, and therefore HCFA's assessment of quality of care is seriously deficient.

Community health department services, overloaded with having to care for suddenly increased numbers of very sick elderly patients, are sometimes forced to cut back significantly on traditional services to other population groups, such as children.

WHAT ARE THE CAUSES OF THESE PROBLEMS?

Cause #1: Inflexible and inaccurate DRG payments provide financial incentives for hospitals to provide inadequate and substandard care to severely ill Medicare beneficiaries.

Cause #2: The financial incentives provided by DRGs encourage hospitals to pressure doctors to treat patients in ways that violate good medical judgement.

Some hospitals are pressuring physicians toward quicker discharges by publicly ranking and comparing those physicians with longer and more costly patient stays to those with shorter money-saving patient stays.

Physicians' decisions to admit or not to admit patients for hospital care often have been based upon inflexible sets of DRG "cookbook" admission criteria.

Cause #3: The PROs have not been asked nor funded by HCFA to comprehensively identify and respond to quality problems experienced by Medicare beneficiaries.

HCFA has placed far too much emphasis on PRO's performing Utilization Review at the expense of Quality of Care Review.

PRO retrospective review of patient cases, performed months after hospitalization, resembles "Monday Morning Quarterbacking" and has cost HCFA and the PROs credibility with physicians and hospitals.

PRO's, doctors, and hospitals have received vague, confusing, and conflicting information from HCFA regarding their responsibilities under the Prospective Payment System.

Existing federal law does not permit PROs to deny payment to a hospital or physician on the basis of poor quality of care.

HCFA's practice of late payments to PROs for services rendered, including quality assurance, is threatening the financial viability of some PROs.

SUMMARY OF COMMITTEE STAFF RECOMMENDATIONS:

Recommendation 1: Congress should promptly enact a set of adjustments to the DRG classification system similar to those recently developed at Johns Hopkins University to better reflect differences in severity of illness between patients in the same DRG category.

Recommendation 2: The Secretary should immediately remind Medicare certified hospitals of the illegality, under Section 504 of the Rehabilitation Act of 1973 (as amended), of discriminating against patients on the basis of their disabilities, and initiate enforcement action where appropriate through the HHS Office of Civil Rights.

Recommendation 3: The Secretary should revise the PRO scope of work, now being drafted by HCFA for the second round of PRO contracts, to require comprehensive quality assurance monitoring and enforcement activities.

Recommendation 4: Congress should pass S. 1623, now incorporated in the Senate Reconciliation package, which would for the first time authorize PROs to deny reimbursement for substandard care provided to beneficiaries under Medicare, while helping to guarantee the financial viability of the PROs.

Recommendation 5: Congress should authorize and appropriate funding levels for the second round of PRO contracts which will reflect the urgent need for at least as high a volume of quality review as utilization review, and which will reflect as well the greater cost per quality review conducted by PROs.

Recommendation 6: Congress should mandate that HHS require a clearly defined appeals procedure for grievances associated with quality for patients, providers and the PROs. The procedures should be consistent and clearly published in PRO and provider manuals. Medicare patients' informed consent forms should clearly include their rights and responsibilities under the prospective payment system.

Recommendation 7: Expand existing law, which provides for "Administratively Necessary Day" payments to hospitals for a patient's extended hospital stay when no nursing home bed is available, to provide for such payments when no appropriate post-hospital placement -- in terms of level of skilled care and quality -- can be found at the time of proposed discharge from the hospital.

Recommendation 8: PROs' responsibilities for quality assurance should be extended so that they are required to track a prespecified percentage of patients discharged from the hospital through the continuum of nursing home, home health and other community-based services.

Recommendation 9: Congress should create within each state a Consumer Advisory Board (CAB) to conduct oversight of the PROs, provide input into the award and evaluation of PRO contracts, and receive input from Medicare beneficiaries and other interested parties. The Board should be coordinated with or otherwise provide for a patient advocacy system to assist the acutely ill elderly and their families. Each Board would be required to make annual reports to the governor and to DHHS. DHHS would be required to utilize CAB input in its decisions to award PRO contracts. The CAB should consist of the long-term care Ombudsman, and Protection and Advocacy officials of each state, and organizations representing the elderly and disabled.

Recommendation 10: Congress should authorize the creation of an interagency panel, consisting of representatives of Congress, Health Care Financing Administration (HCFA), Prospective Payment Assessment Commission (ProPAC), American Medical Peer Review Association (AMPRA), Department of Health & Human Services' Office of Inspector General (OIG), beneficiaries as well as health care practitioner and provider representatives. This panel would make a concerted effort to seek out quality problems, in hospital as well as post-hospital, and would develop criteria for a uniform quality of care review system. This panel would report to Congress as soon as practicable on its findings and recommendations.

IMPACT OF MEDICARE'S PROSPECTIVE PAYMENT SYSTEM ON THE QUALITY OF CARE RECEIVED BY MEDICARE BENEFICIARIES

A Staff Report of the Senate Special Committee on Aging

INTRODUCTION.

This report summarizes the findings of an investigation by Committee staff, conducted over a four month period. Staff visited and collected data from five Peer Review Organizations (PROs), and a number of community and university hospitals. The inquiry involved scores of interviews with Medicare beneficiaries, practicing physicians and nurses, university researchers, and personnel and managers from PROs, hospitals, Health Care Financing Administration (HCFA), and DHHS Office of Inspector General (OIG). In addition, Committee staff gathered and analyzed voluminous records obtained from these organizations and individuals.

Major findings of this inquiry to date are as follows:

WHAT IS THE PROBLEM?

PROBLEM #1: Seriously ill Medicare patients are inappropriately and prematurely discharged from hospitals.

o **Case History:** A 68 year old male with vomiting and dehydration, superimposed on severe emphysema and heart failure, was admitted for treatment of vomiting and shortness of breath. He was found to have a hiatal hernia, accounting for his vomiting, and was noted to have had a worsening of his lung condition. Two days before discharge, intravenous aminophyllin was started to improve his breathing, with some modest improvement. Although neither the vomiting nor the difficulty with breathing was completely resolved, the patient was discharged home on the 8th hospital day. This was precipitated by the doctor's fear that the DRG had expired and that the remainder of the hospital bill would have to be borne by the patient. The patient was told this and insisted on going home because he did not have the money. He died in the driveway of his home.

o **Case History:** A 73 year old man, who had been caring for his adult retarded son, suffered a severe heart attack, hypoxia, and subsequent brain damage. He was discharged on several heart medications to be cared for by the son. After a family member had contacted Social Services the social worker called Home Health, who visited the home 24 hours after discharge. The nurse found the patient staring vacantly into space, sitting in his wheelchair. He had had neither food nor medication since discharge the day before. The son was severely retarded and could neither read nor write. There was no telephone. The only relative in town, a daughter, was in prison. After a call to the doctor, readmission was arranged, with a diagnosis of "confusion".

o **Case History:** A 71 year old woman was sent home after a six day hospitalization. She is legally blind, wears a pacemaker, is a diabetic, has had a stroke, has kidney failure, and had been in the hospital for fluid retention and weakness. The Home Health nurse was not called by the discharge planner for four days. When she arrived at the patient's home shortly after the call, the nurse found the patient alone, with no food in the home, and no one to obtain it. She had been taking the wrong medication dosage, was extremely swollen, and much weaker than before the hospitalization.

o **Case History:** A 64 year old diabetic, a bilateral amputee in kidney failure, received a colostomy after an intestinal perforation because of severe constipation. She was sent home to a dwelling without a bathroom or running water, to be cared for by an often absent 19 year old grandchild. Home Health found the patient with a leaking colostomy, stool actually running into the abdominal wound. Neither instruction to a responsible family member nor supplies for colostomy care had been provided.

PROBLEM #2: Hospital patients who live alone and are too sick to appeal hospital discharge decisions are without any protection under Medicare's Prospective Payment System (PPS).

Many patients in hospitals are living alone and have no relatives living in close proximity when they require hospitalization. Such people are very much at risk of poor treatment or misleading information because of their total dependence upon the hospital. Despite the best intentions of doctors, nurses and the other personnel dedicated to providing the highest possible quality of care, PPS creates financial incentives for abuse or neglect, but fails to provide a system of support and advocacy for the hospitalized frail aged.

Although Congress has created the nationwide Long Term Care Ombudsman program to advocate for the rights of nursing home and residential care facility residents, there is no comparable network of patient advocates working on problems in acute care.

Similarly, recognizing the vulnerability of the aged institutionalized, the federal government has mandated a set of minimum "Patients' Rights" for nursing home residents. No such list of statutory rights and protections exists at present for such persons when they are receiving care in the hospital.

PROBLEM #3: Many patients, especially the terminally ill and their families, are being given false and incomplete information

on their rights of discharge appeal and on options for post-hospital care.

o Case History: An 88 year old woman who was diabetic was hospitalized after suffering a massive heart attack and stroke. She could not feed herself, ring for a nurse , or speak. On the 12th day of hospitalization, the patient's daughter was told inappropriately that her "mother's time in the hospital was up," and that "DRGs controlled the number of days anyone over 80 could stay in the hospital for any given illness." The patient was discharged to a nursing home.

o Case History: A 75 year old woman, who had undergone major abdominal surgery, was rehospitalized for a major heart attack. During the second hospitalization, she experienced cardiac arrest and stroke. The daughter of the patient was told by a hospital social worker that her mother had to be moved to a nursing home, or she would lose Medicare coverage. According to the daughter, at no time was she informed of her rights to appeal the hospital discharge of her mother.

o Case History: An 85 year old woman who suffered from kidney failure, high blood pressure, blindness and deafness, was hospitalized after suffering a heart attack. After the patient had spent three weeks in the hospital, the daughter was told that "the hospital could no longer take care of her mother" and that her mother "would have to go to a nursing home because she no longer required acute level of care." According to the daughter, she did not become aware of the right to appeal her mother's discharge until she received a letter in the mail from the hospital after her mother's death.

Federal regulation requires that a hospital inform a Medicare patient -- or person acting in their behalf -- of their rights to appeal a hospital-initiated denial, but **only** if the hospital intends to collect private payment for the patient's continued stay in the hospital. This would appear to be a loophole in the law that allows the situations described above to occur legally.

HCFA's instructions to the PROs on enforcing these regulations are as follows:

"Hospitals reimbursed under PPS are permitted to issue denial notices to Medicare patients under the conditions for PPS payment (42 CFR 412.42(c)). A hospital may issue a denial notice during a stay if the hospital (acting directly or through its utilization review committee) determines that the beneficiary no longer requires inpatient hospital care, and (1) the attending physician concurs with the decision in writing (for example, by issuing a written discharge order); or (2) the PRO reviews the care and concurs with the decision of the hospital."

HCFA's instructions list the required content of any notice that the hospital may elect to give to the beneficiary. Significantly, the rules state that the notice must inform the beneficiary, in writing, among other things, of the agreement of the attending physician regarding the discharge. This provision may provide a disincentive for attending physicians to insist that the hospital provide notice to their patients.

PROBLEM #4: Some hospitals have denied admission to patients with multiple serious conditions.

o **Case History:** A 94 year old woman developed trouble swallowing as a chronic complication of multiple other illnesses. This resulted in several choking spells that frightened the family, who feared she might die in one of these episodes. The doctor likewise was concerned, both with regard to the possibility the patient might have a terminal event and with regard to the malpractice liability, should he not hospitalize the patient. When her family brought the patient to the Emergency Room, neither the hospital nor the PRO representative, who happened to be onsite, would authorize the admission under Medicare.

o **Case History:** A family practitioner saw a patient in his office for chest pain of four days' duration. He performed a cardiogram which was negative. Other studies were also negative and the patient was allowed to go home. He returned the next morning and was sent to the Emergency Room where IV fluids were started and studies initiated. The patient expired soon after arriving in the ER. The doctor, in discussing the case later,said, "You know, I feel so terrible about this case. I would have admitted him the day before except for those DRGs".

For reasons related to those discussed above in relation to premature and inappropriate discharge, hospitals are seeking to avoid admitting patients who may wind up costing more money than the Medicare reimbursement will provide.

Administrators engage in pre-admission screening activities to avoid being surprised several months later by a retroactive PRO denial that would cost the hospital reimbursement they budgeted as a receivable, as well as the expense of care provided. The net effect of a retroactive denial on a hospital's financial postion provides a substantial incentive to "screen" potentially costly patients before they are admitted.

Therefore, administrators ask attending physicians to evaluate cases prior to admitting them. In addition, although DRGs are not a precise way of measuring patient attributes, hospital administrators may seize upon computerized DRG analysis of previous admissions to the hospital in a desperate attempt to identify "loser" DRGs, in hopes of "screening" patients who might be profitably excluded from admission to the hospital.

As Dr. Horn of Johns Hopkins University has pointed out, the most severe cases in a given DRG are not evenly distributed over all hospitals. Some institutions tend to see more severely ill patients, such as certain public and not-for-profit hospitals. PPS has therefore fueled an existing incentive, which encouraged hospitals to refer their heavier care patients to the public institutions in the area, particularly if the public hospital also served as a regional referral center by virtue of its "mission" in the community or its superior facilities.

For example, the administrator of one Tennessee hospital, a regional referral center, told Committee staff that the constant flow of heavier care patients from nearby proprietary community hospitals was costing his institution much more than Medicare's DRGs would recognize. This hospital appeared to have "state of the art" computer capability whereby it sought to track expenses and income by patient, physician, and DRG. These technical and administrative innovations, moreover, have only served to carefully document the worsening financial situation of this hospital, which has continued to serve a severely-ill population referred by other facilities. The social circumstances of this hospital could not be resolved by superior technology.

Further analysis of the data supplied by Drs. Brodsky and Ezell of the University of Tennessee at Chattanooga reveals widespread agreement among public and not-for-profit hospital adminstrators that DRG categories are too rigid and are unable to accurately capture the characteristics of the severely ill aged in many DRG categories. Analysing their survey responses by ownership type, these researchers found 86% of public and not-for-profit hospital administrators felt DRGs inadequately described the condition of patients being admitted to their hospitals. Fewer of investor-owned hospital administrators (54%) believed this is a serious problem.

HOW EXTENSIVE ARE THESE PROBLEMS?

Existing Medicare data do not allow a precise answer to be given. There are, however, significant indications that these problems are more severe and widespread than current HCFA estimates, based upon the very limited information available from Medicare's PROs, would indicate.

The Health Care Financing Administration has focused the PROs on a very narrow and incomplete set of quality issues, and therefore HCFA's assessment of quality of care is seriously deficient.

Periodically over the past year, representatives of the Department of Health and Human Services and its Health Care Financing Administration have testified before Congress regarding quality of care assurance. The Congress has been repeatedly assured that there are no significant quality of care problems resulting from implementation of the Medicare Prospective Payment System.

Yet, HCFA's own reports, as interpreted by the DHHS OIG months ago, raised serious concern over premature and inappropriate discharges reported by some of the PROs. Figures ranging from 2,000 to more than 3,000 premature discharges have been quoted over the past several months. The Inspector General is currently reviewing all of the premature discharges reported by the PROs.

Regardless of what the number of premature discharges may turn out to be, the Committee's investigation had found that a number of other very serious quality of care issues are not being addressed at all.

PRO executives and medical directors interviewed by Committee staff have indicated their disatisfaction with the level of resources and attention they are able to focus on quality review under PPS. In fact, the American Medical Peer Review Association (AMPRA) has distributed a position paper which asserts that:

"The present quality assurance system required under PRO contracts is limited, restrictive, and lacks the innovation needed at a time when the incentives of PPS raise the potential for compromised care. The imposition of quality objectives presupposes baseline data that can validate the existence of quality problems. No such data is available across a wide spectrum of inpatient care to the elderly and only now are quality care concerns surfacing as the PPS system is implemented and gains momentum over time."

The Committee's study of PRO quality assurance activity supports AMPRA's contention that to view existing government data as any definitive indicator of "poor care" would be misleading. Quality problems not reviewed by PROs under the existing system are:

a. rehospitalizations occurring after 7 days;
b. deaths at home associated with hurried hospital discharge;
c. medical complications, including death, brought about by denial of hospitalization;
d. nursing home refusal to take heavy care patients, and the practice of nursing homes filling beds meant for sick patients with essentially well patients in an effort to maximize profit;
e. failure to prepare patients adequately for home care, including failure to arrange nursing and/or medical follow-up;
f. inappropriate reliance upon Home Health nursing services when a case requires more extensive supervision;
g. quality problems resulting from outpatient treatment.

Community health department services, overloaded with having to care for suddenly increased numbers of very sick elderly patients, are sometimes forced to cut back significantly on

traditional services to other population groups, such as children.

One indication of the extent of the problems caused by inappropriate and premature discharge is data from community agencies regarding demand for post-acute services.

Some county health department have opted to become deeply involved in home health care, whereas other counties have left all such services to be provided by private agencies. Home health services provided by either public or private agencies are designed to give nursing or paramedical support services in the home environment for patients eligible under Medicare guidelines, and to those able to pay privately.

In one county where the health department has assumed much of the increasing home health load, the total number of new home health patients entering the system increased from 312 in 1983-84, when PPS was just beginning, to 447 in 1984-85, an increase of 43%. Of those considered to be seriously ill, the number increased from 115 to 166 patients, a 44% increase. The following table outlines increases in hours committed by Registered Nurses (RNs), Physical Therapists (PTs), and Speech Therapists (STs).

	RN Hours	PT Hours	ST Hours
1983-84	11758	1032	49
1984-85	15797	1173	356
% Increase	34%	14%	627%

The cost to the County of providing these services, estimating the charge at $45 per visit, increased from $214,335 in 1983-84 to $405,000 in 1984-85. The administrator of the Home Health agency stated to Committee staff that the patients being sent home in his community are now often "Intensive Care level", and often inappropriate for discharge. One to two of these medically inappropriate discharges have been received into the Home Health service weekly for at least the past eighteen months.

Hospital discharge planning has apparently been lax in that patients often are sent home without medical equipment and devices needed for home care. Neither the patient nor the family is in many cases familiar with, much less comfortable with, the procedures necessary to care for the very sick elderly patient.

The following patients, for example, are among those entering this County home health caseload for the month of August, 1985:

1. 76 year old man with chronic obstructive pulmonary disease (emphysema, bronchitis) End Stage (terminal).
2. 62 year old woman with intestinal obstruction, a colostomy, and an abscess about the colostomy.
3. 84 year old woman with end-stage pulmonary fibrosis.
4. 86 year old man with congestive heart failure.
5. 82 year old woman with kidney failure.
6. 61 year old woman with lung cancer.
7. 78 year old man with Parkinson's disease.

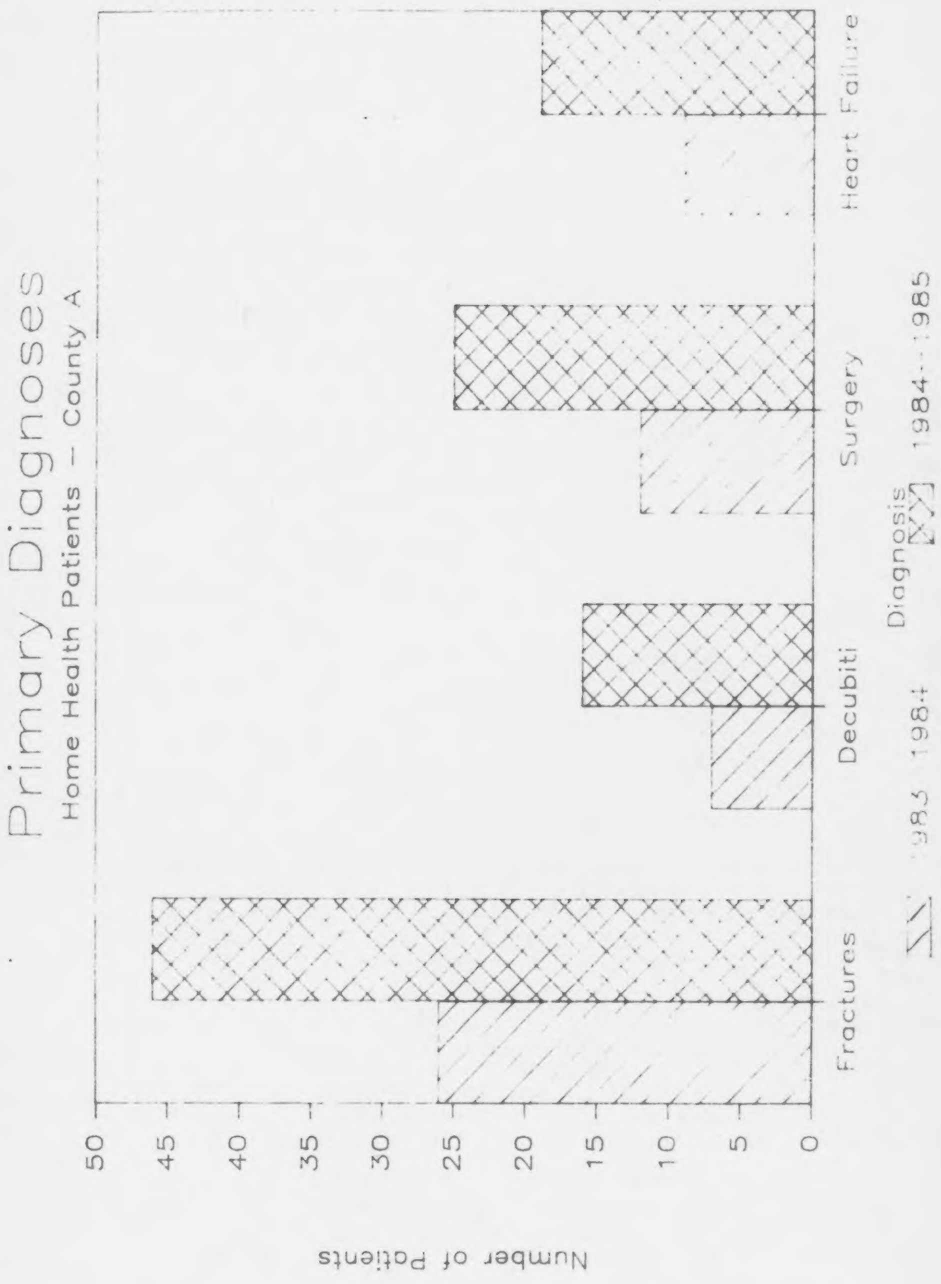
The bar chart appearing on the next page shows graphically the tremendous increase in the number of patients with serious health problems who are being cared for by this County's home health personnel.

The complex and intricate nature of the care involved, from simple items, such as frequent position change to prevent bedsores to procedures such as tube feeding, require a major committment of nursing time.

To alleviate the problem, the two full time nurses in Home Health are assisted by the eleven general public health nurses usually assigned to other duties. Consequently, there has been an approximate 50% reduction in time devoted to programs such as school health, maternity follow-up home visits, immunizations, and infectious disease follow-up and education. School Health two years ago provided for about 1 to 2 days per week in each school for a nurse. Today less than 1/2 day weekly is available per school.

Perhaps of greater concern to those with an interest in health care for the elderly, are the so-called "chronic care" patients, those who, like home health patients, are sick and living at home but who are not eligible for home health by virtue of strict Medicare guidelines. Like the other groups suffering cutbacks, these patients too now receive fewer resources and less time.

In another county with virtually no public agency or health department involvement in home health, these patients appear to receive no resources at all, except as may be provided by private charities.


Primary Diagnoses
Home Health Patients – County A
Number of Patients
0
5
10
15
20
25
30
35
40
45
50
Fractures
Decubiti
Surgery
Heart Failure
Diagnosis
1983 1984
1984–1985

WHAT ARE THE CAUSES OF THE PROBLEM?

Cause #1: Inflexible and inaccurate DRG payments create financial incentives for hospitals to provide inadequate and substandard care to severely ill Medicare beneficiaries.

As the above case histories suggest, patients most affected by premature and inappropriate discharges are those with multiple and often chronic conditions, including diseases that may or may not be related to their principal diagnosis. The present payment system provides incentives for hospitals to respond differently to two patients who are categorized in the same DRG, with the same payment rate, but who may be dramatically different in terms of their overall health and responsiveness to treatment. Hospitals are learning that it is in their best interest to see one patient as a "DRG winner", while another could be a "DRG loser".

For example, a patient with no other health problems may come in to a hospital for the surgery called "transurethral prostatectomy" for a benign prostatic enlargement, and perhaps also be afflicted with bloody urine, and a urinary tract infection. Another Medicare patient may come in with these same problems for the same surgery but also be afflicted with urinary incontinence, chronic renal failure, hypertension and perhaps even Alzheimer's disease, and/or cataracts. The DRG payment for both patients -- the simple and the complex cases -- would be the same.

Hospitals may end up spending a great deal more on a patient with many diseases and chronic conditions than they would on another patient in the same DRG category but with few complicating problems. This problem can be exacerbated if nursing homes in the area or the patient's family are unable to deal with the combined care needs of the patient with complex and overlapping conditions, making it difficult to responsibly discharge the patient to another person's care.

The heart of the prospective payment system is the fairness and accuracy of pre-set rates of payment for services rendered. For Medicare's hospital reimbursement system, this means that rates paid should accurately and closely reflect the reasonable cost of providing high quality care to beneficiaries.

Diagnosis Related Groups (DRGs) were the best method available, when PPS was enacted in 1983, to measure differences in patient health and the cost of caring for those patients. Hospital and doctor experience with PPS, however, as well as recent scholarly research, shows that DRGs poorly account for differences between patients, and suggests this problem can be corrected systemwide with methods now available.

Researchers Brodsky and Ezell at the University of Tennessee at Chattanooga have developed findings revealing a substantial number of physicians (49%) and hospital administrators (68%)

believe DRGs are "too rigid and not well-suited either to complications of individual cases, unexpected developments and multiple conditions among older people".

This research, funded with a grant from the Andrus Foundation of the American Association of Retired Persons (AARP), is based upon a survey of these health care professionals conducted since Medicare's Prospective Payment System (PPS) was implemented in the 10 county Southeast Tennessee Development District.

Their findings are supported by sophisticated studies conducted at Johns Hopkins University over the past several years and published in the New England Journal of Medicine last July 4th. By comparing rates of reimbursement based on Medicare's DRG-based approach with the actual severity of illness of the patient population, researchers determined that DRGs often fail to account for the severity of a patient's illness, "a major determinant of the actual cost of hospital care".

According to Dr. Horn of Johns Hopkins, the Health Care Financing Administration (HCFA) has recently acknowledged that DRGs describe individual patient characteristics poorly. HCFA officials are asserting that on a hospital-wide basis, these inaccuracies "average out". According to HCFA's view, for some patient cases a hospital will be under-reimbursed by Medicare, and for some over-reimbursed, but the hospital will be fairly and accurately reimbursed for its costs of caring for Medicare patients after all the individual "winner and loser" cases are added up over an extended period of time.

The Johns Hopkins researchers tested HCFA's reasoning in further research, the results of which are to appear in the October 1985 issue of the Journal of the American Public Health Association. First, their findings reveal that under DRGs one hospital would be paid over 59% more than its actual cost per case, while another institution was underpaid by 26% of its actual cost of providing care.

Second, when the researchers modified the DRGs with a "Severity of Illness Index", designed to take more of the patient's conditions into account, payment was much better matched to the hospitals' actual costs of providing care. Dr. Horn's findings suggest that the difference between unadjusted DRGs and Severity adjusted DRG payments to individual hospitals "could be greater than 35% of a hospital's total operating costs".

These findings suggest HCFA is wrong in its belief that unadjusted DRGs are fair to hospitals when all cases in the institution are considered in the aggregate. Instead, it appears that a Severity-adjusted Medicare DRG system should be implemented as soon as it is feasible on a national scale, to update the system and eliminate some of the arbitrary aspects of the 1983 DRG methodology.

Cause #2: The financial incentives provided by DRGs result in hospitals pressuring doctors to treat patients in ways that violate good medical judgement.

Some hospitals are pressuring physicians toward quicker discharges by publicly ranking and comparing those physicians with longer and more costly patient stays to those with shorter, money-saving patient stays.

Many people believe that physicians are capable of being the conscience of the Prospective Payment System. According to this view, doctors are supposed to stand up for the patients' needs and forbid the hospital from prematurely discharging the patient, because of their independence and professional orientation. Yet, hospitals hold many strings that are directly connected to the physician's livelihood, and they are becoming more bold in tugging on those strings when doctors forget the institution's financial interest.

Physicians have provided the Committee with copies of computer print-outs, generated by hospitals they practice in, which depict, by patient and by DRG, key financial data about individual patients treated by the doctor at the hospital.

Generally such a print-out contains the physician's and the patient's name (or number), together with the hospital's usual charges, actual costs, the DRG reimbursment amount, and the net profit or loss for the patient's hospital stay is detailed on the print-out. Hospitals generate these print-outs monthly, quarterly, and/or annually, and generally distribute them to the physician him or herself. By "profiling" physicians' practices in this fashion, the administrator has an effective method of reminding doctors of the hospital's interest in the way they treat patients.

Physician profiling has become quite common in American hospitals since PPS was implemented, although it pre-dates PPS at some institutions. At least one rural hospital contacted by Committee staff still has no such computerized system in place. For physicians who often treat the poor and patients with multiple chronic conditions underlying an acute problem, these analyses will frequently reveal that the physician is costing the hospital money. One witness pointed out that doctors who routinely accept more difficult cases on referral from their colleagues will also be shown up as "losers" in such an analysis.

One physician told the Committee of a hospital which posted a ranking of attending physicians in the doctors' lounge. On this list, physicians with the most profitable practice for the hospital appeared at the top of the list, and those whose practice had generated losses for the hospital were ranked at the bottom of the list. The meaning of a financial hierarchy such as this is clear to others working in the hospital, whether they are other doctors, nurses, or administrators.

One physician has supplied the Committee with internal hospital executive committee memoranda stating the institution's policy of threatening doctors who "overutilize", according to this sort of analysis, with non-renewal of their privileges at the hospital.

Not only are such techniques intimidating, but they are probably methodologically flawed, as well. Another Johns Hopkins University study by Dr. Horn and her colleagues suggests that hospital administrators who attempt to "rank" profitable and unprofitable physician practices at their hospitals will often incorrectly identify "problem" physicians.

After comparing DRG-based physician profiles to similar DRG profiles that had been adjusted for severity of illness, the authors were able to conclude "37% of the physicians in the study may be wrongly identified as over- or under-utilizers" by hospital administrators who rely upon unadjusted DRGs for these analyses.

Physicians' decisions to admit or not to admit patients for hospital care have been based upon inflexible sets of DRG "cookbook" admission criteria.

Physicians interviewed by Committee staff have described the procedure they follow in deciding whether to admit a patient. The first decision appears to be what DRG would most likely cover the cost of the admission. The second decision has to do with the level of care that might be appropriate. At this point, according to witnesses, physicians take into account the patient's real needs, and either "fudge" the diagnosis (stretch the truth to provide enough hospital care to cover the admission) or must decide to administer treatments that are not really indicated. Some examples of these treatments are injectable pain relievers, and intravenous fluids.

If the physician fails to do this, they may be faulted later by the hospital Utilization Review Committee for keeping patients too long. If the doctor, anticipating the Utilization Review Committee complaint, sends the patient home within the DRG guideline, s/he risks having to readmit the patient later. In either of these instances the doctor may be faulted by the PRO for poor patient care. Thus the doctor is often placed in the position of cheating the system and caring for his patients or following the system and taking the consequences.

Cause #3: The PROs have not been asked nor funded by HCFA to comprehensively identify and respond to quality problems experienced by Medicare beneficiaries.

HCFA has placed far too much emphasis on PRO's performing Utilization Review at the expense of Quality of Care Review.

Utilization Review, historically a hospital function wherein physicians review retrospectively the admission, treatment, and discharge practices of other physicians on staff, has been taken beyond the scope of the hospital and is now performed regionally by the PRO's for Medicare patients. This practice does not replace the traditional hospital Utiliization Review. It represents instead yet another layer of review to which the Medical Records department of the hospital and the physicians must respond.

The PRO review is unique in two ways. First, it is performed by doctors outside the community, with varying degrees of familiarity with the patient community and with the capabilities of the hospital involved.

Second, the review as performed by the PRO is itself multilayered. Nurse Reviewers typically review charts on site at the local hospital and request xerox copies of those charts apparently reflecting DRG-related problems. These copies are returned to physican reviewers who work under contract for the PRO. A portion of these copied charts will form the basis for denials of Medicare payment. Each of these denials will likely be appealed both verbally and in writing by the hospital and doctor. Ultimately another PRO physician or physicians will review the same documents plus others submitted in the appeal process. The system appears to be both redundant and expensive.

One major teaching hospital in North Carolina noted for example, that the PRO last year requested copies of portions of 568 patient charts, averaging 30 pages per chart, as well as documents relating to 31 cost outliers, 20 complete charts for appeal purposes, and 11 charts for the SuperPro reivew. The estimated cost in paper alone was $3,300. Three clerks and one nurse were hired, at an annual cost of $93,865, to respond to and work with the PRO. Since documents copied by the PRO are also copied for internal administrative records at the hospital, one clerical position in the hospital is devoted entirely to copying. The total cost in work-hours, including 1/2 of an administrator's time, was 9,360 hours for last year.

In a small community hospital (250 beds) in the same state, the cost to the hospital for clerical and nursing salaries and for copying will be approximately $26,000 this year, all of which is expended to meet PRO requirements. This will be paid for by cuts in nursing staff and sevices, already implemented.

These retrospective review procedures are not only cumbersome but they are also easily circumvented. A number of physicians have told Committee staff of deliberate entry of untrue information into the patient chart either retrospectively or prospectively in an effort to force the case to fit DRG criteria. Clearly, the system will reward the artful distortion of fact but likely punish the physician who is a poor documenter. One physician interviewed by Committee staff has suggested that hospital administrators are sometimes directly implicated by encouraging this form of creative writing.

PRO retrospective review of patient cases, performed months after hospitalization, resembles "Monday Morning Quarterbacking" and has cost HCFA and the PROs credibility with physicians and hospitals.

o **Case History:** A patient with urological problems was admitted to the hospital for fulgeration (sudden, intense, stabbing pains) of a bladder tumor. She remained in the hospital three days and had no bleeding so she was discharged. Three days later she hemorrhaged at home and was readmitted. Her first admission was denied by the PRO as unnecessary. Her second admission was later denied by the PRO because she was discharged too soon in the first admission. These denials are reportedly under appeal.

Utilization Review of a physicians work within a hospital is performed by specialists in the same field having expertise in both the specialty and the community, as well as having the benefit and capabilities of the hospital's diagnostic facilities. PRO review is, however, under current contract provisions, performed by outsiders. The first review is by nurses. The second review is by a doctor who may or may not have expertise in the area under review. If the PRO's doctor retrospectively questions the treating physician's work, the denial process is triggered. Medically, the decisions reached by the PROs are often arguable. In one community hospital, for example, a retrospective Utilization Review Committee evaluation of all charts of patients for whose care reimbursement had been denied by the PRO found 80% of the cases to represent appropriate medical care for that hospital in that community.

Physicians interviewed by Committee staff uniformly protested that it was unreasonable and unfair to subject their day-to-day decisions to review by an academic expert using textbook criteria, imposed after the fact and in full knowledge of the eventual twists and turns of the case diagnostically.

Other common complaints expressed to Committee staff by physicians and hospital administrators are that the patient's socioeconomic status, ability to handle self care, and support or lack thereof from family members are not considered by the PRO reviewers during their attempts to determine the appropriateness of an admission or the timing of a discharge. The numerical diagnosis and copied hospital records simply fail to adequately characterize the patient or his need for medical care.

One reform might make the PRO system more effective and more palatable to the medical community. A better approach might be the incorporation of a local medical reviewer at an early stage in the review process. The incorporation of local physicians in the ranks of PRO reviewers has been suggested by many physicians concerned with the insensitivity of the system to local practices and conditions. Perhaps a change in PRO procedures, providing for actual onsite inspection of patient records by the

PROs' contractor physician reviewers would avoid much needless copying, letter writing, meeting, and subsequent appealing.

PRO's, doctors, and hospitals have received vague, confusing, and conflicting information from HCFA regarding their responsibilities under the Prospective Payment System.

Although much time and effort has been devoted to the selection of PROs and the negotiation of contracts between PROs and hospitals, very little time appears to have been invested by HCFA in education of the hospitals or physicians. Some hospital staffs entered the DRG system with long-term planning and in-house seminars while others took notice of the system only after encountering the denial process.

Some hospitals have been confused by HCFA's attempts to educate them regarding the new rules accompanying PPS. For example, one PRO visited by Committee staff documented their frustration with a series of policy revisions and inspections by HCFA, which ultimately resulted in six memoranda being issued by the PRO to area hospitals -- all "clarifying" how physicians and re-clarifying how physicians should sign their names on the medical record.

Inconsistency in HCFA administration has been a problem in two areas. First, policy changes within HCFA in response to arguments and complaints from the PRO's have resulted in reconsideration of previously denied cases, often with reversal of decisions months after the fact. This is of course understandable in any evolving system. Less understandable, however, is a failure on HCFA's part to provide meaningful administrative guidance on a day to day basis to the PRO's. Questions are often met with conflicting advice and decisions handed down in an authoritative manner that are not uncommonly changed by other HCFA administrators. A common complaint is that no one at HCFA, either regionally or at headquarters, seems versed in all aspects of the system. Direct and meaningful access to persons at HCFA capable of making line decisions appears to be a critical need.

HCFA audits of the PROs are generally regarded by PRO personnel as situations wherein one volunteers nothing. With regard to quality of care issues, one PRO administrator said of HCFA that the agency had no interest in knowing about such things, stayed to a "checklist" evaluation format, and that such problems would "never" be reported to HCFA. There would in fact appear to be a general lack of respect for HCFA by PRO, hospital, and physicians alike. Once again, communication, distance and anonymity seem to be the underlying causes.

Existing federal law does not permit PROs to deny payment to a hospital or physician on the basis of poor quality of care.

A gaping loophole currently exists in the PRO program for assuring quality of care. The 1982 amendments to the Social

Security Act concerning "Functions of Peer Review Organizations" provides for denial of Medicare reimbursement payment to health care providers in cases of overutilization. Section 1154 of the Tax Equity And Fiscal Responsiblity Act of 1982, however, specifically excludes provision for denial of payment on the basis of substandard care or poor quality of services.

Thus, while being charged with the responsibility of assuring quality of care, the PROs were denied the essential mechanism for enforcement. This very serious loophole must be closed in order for the PROs to adequately fulfill the Congressional mandate to assure quality of care.

HCFA's practice of late payments to PROs for services rendered, including quality assurance, is threatening the financial viability of some PROs.

Some of the PROs are facing financial crisis caused by HCFA's delays in paying them. PROs spend tens of thousands of dollars each month in fulfilling their contractual responsibilities, but often must wait as much as 45 to 75 days past the end of each before being compensated under the terms of their contracts with HCFA.

The problem is rooted in the payment system, which is based on procedure used in dealing with mammoth defense contractors. For example, IBM or Boeing can weather a late government payment without suffering a cash flow problem. But to many of the PROs, which employ little more than 100 staff and are generally non-profit organizations, delays in payment can determine whether the payroll will be met.

As many as 14 PROs, charged with protecting some 1/3 of Medicare beneficiaries, have indicated that continued latelate payments could push them into deficit, and could force them into borrowing money to meet payrolls.

The problem of late payment to the PROs must be corrected, as it can not help but impact on PRO efforts to assure quality of care.

SUMMARY OF COMMITTEE STAFF RECOMMENDATIONS:

Recommendation 1: Congress should promptly enact a set of adjustments to the DRG classification system similar to those recently developed at Johns Hopkins University to better reflect differences in severity of illness between patients in the same DRG category.

Recommendation 2: The Secretary should immediately remind Medicare certified hospitals of the illegality, under Section 504 of the Rehabilitation Act of 1973 (as amended), of discriminating against patients on the basis of their disabilities, and initiate enforcement action where appropriate through the HHS Office of Civil Rights.

Recommendation 3: The Secretary should revise the PRO scope of work, now being drafted by HCFA for the second round of PRO contracts, to require comprehensive quality assurance monitoring and enforcement activities.

Recommendation 4: Congress should pass S. 1623, now incorporated in the Senate Reconciliation package, which would for the first time authorize PROs to deny reimbursement for substandard care provided to beneficiaries under Medicare, while helping to guarantee the financial viability of the PROs.

Recommendation 5: Congress should authorize and appropriate funding levels for the second round of PRO contracts which will reflect the urgent need for at least as high a volume of quality review as utilization review, and which will reflect as well the greater cost per quality review conducted by PROs.

Recommendation 6: Congress should mandate that HHS require a clearly defined appeals procedure for grievances associated with quality for patients, providers and the PROs. The procedures should be consistent and clearly published in PRO and provider manuals. Medicare patients' informed consent forms should clearly include their rights and responsibilities under the prospective payment system.

Recommendation 7: Expand existing law, which provides for "Administratively Necessary Days" payments to hospitals pay for a patient's extended hospital stay when no nursing home bed is available, to provide for such payments when no appropriate post-hospital care placement -- in terms of the level of skilled care and quality -- can be found at the time of proposed discharge from the hospital.

Recommendation 8: PROs' responsibilities for quality assurance should be extended so that they are required to track a prespecified percentage of patients discharged from the hospital through the continuum of nursing home, home health and other community-based services.

Recommendation 9: Congress should require within each state the creation of a Consumer Advisory Board (CAB) to conduct oversight of the PROs, provide input into the award and evaluation of PRO contracts, and receive input from Medicare beneficiaries and other interested parties. The Board should be coordinated with or otherwise provide for a patient advocacy system to assist the acutely ill elderly and their families. Each Board would be required to make annual reports to the governor and to DHHS. DHHS would be required to utilize CAB input in its decisions to award PRO contracts. The CAB should consist of the long-term care Ombudsman, and Protection and Advocacy officials of each state, and organizations representing the elderly and disabled.

Recommendation 10: Congress should authorize the creation of an interagency panel, consisting of representatives of Congress, the Health Care Financing Administration (HCFA), the Prospective Payment Assessment Commission (ProPAC), the American Medical Peer Review Association (AMPRA), the Department of Health and Human Services' Office of Inspector General (OIG), beneficiaries, and health care practitioner and provider representatives. This panel would make a concerted effort to seek out quality problems, in hospital as well as post-hospital, and would develop criteria for a uniform quality of care review system. This panel would report to Congress as soon as practicable on its findings and recommendations.

IMPACT OF MEDICARE'S PROSPECTIVE PAYMENT SYSTEM ON THE QUALITY OF CARE RECEIVED BY MEDICARE BENEFICIARIES

Staff Report

Special Committee on Aging,
United States Senate
John Heinz, Chairman

October 24, 1985

IMPACT OF MEDICARE'S PROSPECTIVE PAYMENT SYSTEM ON THE QUALITY OF CARE RECEIVED BY MEDICARE BENEFICIARIES:

Impact on The Post-Hospital Continuum of Care

EXECUTIVE SUMMARY

INTRODUCTION.

This staff paper of the Senate Special Committee on Aging summarizes the findings of an investigation of the impact of Medicare's Prospective Payment System (PPS) on patients' access to quality services after discharge from an acute hospital. The inquiry involved scores of interviews with Medicare beneficiaries, practicing physicians, nurses, discharge planners, university researchers, long term care Ombudsman advocates, and personnel and managers from the Health Care Financing Administration (HCFA). In addition, Committee staff gathered and analyzed voluminous records obtained from these organizations and individuals.

Major findings of this inquiry to date are as follows:

WHAT ARE THE PROBLEMS UNDER MEDICARE'S PPS?

PROBLEM #1: Under PPS, large numbers of Medicare patients who still need heavy medical care are being discharged from hospitals into their communities for care.

- o A Committee staff report and testimony given before the Committee on September 26, 1985 established that many seriously ill Medicare patients are being inappropriately and prematurely discharged under PPS.
- o Since implementation of PPS there has been a 40 percent increase in discharges to skilled nursing facilities and a 37 percent increase in discharges to home health care.
- o The increasing demand on nursing homes to care for Medicare patients has reduced the already insufficient supply of beds available to non-Medicare patients.

PROBLEM #2: Home health and nursing home care in the community is often unavailable or substandard.

- o There is a severe shortage of nursing home beds nationwide. According to testimony before a hearing of the Special Committee on Aging on October 1, 1984, Medicare and Medicaid beneficiaries suffer from widespread discrimination in finding a nursing home bed.

- Federal and State government reimbursement rules are based on arbitrary "levels of care" that encourage nursing homes to deny admission to patients who need care.

- More than 970 nursing homes have been chronically substandard for years, according to HCFA data, but these facilities still retain their certification to receive Medicare and Medicaid patients.

- Significant cutbacks and redefinitions in the Medicare home health benefit have resulted in an increased demand on families, most of whom are ill-prepared to provide care for recently discharged and severely ill patients.

PROBLEM #3: Hospital discharge planning -- the only mechanism available to ensure patients are placed in appropriate community settings -- is seriously taxed under PPS and often provides inadequate services to Medicare patients.

- Many hospitals have invested insufficient resources in discharge planning. According to a national survey of hospital discharge planners, caseload since PPS has risen faster than resources and, as a result, necessary follow up on patients has suffered.

- Federal rules designed to ensure appropriate discharge planning, though already lax, are scheduled for deregulation.

PROBLEM #4: The Department of Health and Human Services has failed in its Congressionally mandated responsibility to monitor and report on PPS impact.

- In early 1983 Congress mandated that the Department complete by December 1984 a study on PPS impacts, including quality of care. This report, now 10 months overdue, has yet to be completed and sent to Congress.

- Congress mandated a study of the impact of PPS on nursing home care. That study, due December 1983, is now 22 months overdue and has not been sent to Congress.

- The Health Care Financing Administration scrapped a study of PPS impact on skilled nursing facilities and decided not to publish a report on PPS impact on home health care agencies.

- o The only regular reports on the effects of PPS -- the "Report on PPS Monitoring Activities" -- are for internal HCFA use only and contain no reference to quality of care.

STAFF RECOMMENDATIONS.

RECOMMENDATION #1: Withhold portion of HHS appropriation for FY86 until PPS Impact on Nursing Homes report, with recommendations for reimbursement reform (due 12/31/83), and first Annual PPS Impact Report (due 12/31/84) are delivered to Congress.

RECOMMENDATION #2: DHHS should voluntarily suspend plans to deregulate hospital quality assurance until it reports to Congress on the impact of PPS.

RECOMMENDATION #3: Eliminate current "level of care" distinctions governing nursing home reimbursement under Medicaid, concurrently with mandatory State phase-in of a reimbursement system based upon patients' individual needs and characteristics.

RECOMMENDATION #4: Expand advocacy assistance for older Americans. (1) Authorize Long Term Care Ombudsman to have access to hospitalized Medicare patients, interview hospital personnel and, with patient's permission, examine complete hospital record; Mandate State Ombudsman representative on PRO advisory or corporate board; (2) **Fund training** of Ombudsmen in (a) Medicare PPS and (b) all Medicare Part A appeals; (3) **Establish** funding formula for Ombudsman programs based upon workload; (4) **Provide** Ombudsmen with immunity from suits for good faith performance of duties.

RECOMMENDATION #5: Improve Protections for Nursing Home Residents. Congress should enact a minimum set of sanction authorities, which would: (1) **Empower** State enforcement officials to impose receivership on substandard nursing homes, (2) **Provide** Federal Financial Participation (FFP) for care of residents during the period of a receivership; (3) **Strengthen** the Patients' Rights; (4) **Authorize** States to impose civil penalties and suspend reimbursement at noncompliant providers; (5) **Expedite sanction** & provider appeal at chronically substandard nursing homes; (6) **Prohibit discrimination** in admission or treatment of patients based on source of payment; (7) **Empower residents** to enforce provider agreement with private right of action; (8) **Impose moratorium** on HCFA's scheduled January 1986 implementation of new nursing home inspection survey system ("PACS"), for public review and comment.

RECOMMENDATION #6: Authorize and fund PROs to do expanded quality of care reviews to (1) nursing homes and home health care agencies to ensure that quality care is planned and delivered after the patient's discharge from a PPS hospital; **(2)** Increase PRO reviews of readmissions to those occurring within period 30 days.

RECOMMENDATION #7: Restructure Medicare's eligibility determination and appeals process. (1) Adopt uniform needs assessment tool for post-hospital benefits, based upon patients' functional abilities; **(2) Institute PRO pre-discharge** eligibility determination for Medicare and Medicaid benefits, with opportunity for patients to initiate appeal prior to discharge; **(3) Eliminate 3-day** prior hospitalization requirement for Medicare SNF benefit; **(4) Mandate appeal** opportunity for beneficiaries when provider fails to submit claim; **(5) Create penalties** for fiscal intermediaries or PROs that improperly deny benefits; **(6) Retain Waiver of Liability** protections for providers.

RECOMMENDATION #8: Congress should upgrade Federal rules for hospital discharge planning to include **(1) Pre-discharge consultation** between all professionals giving care to the patient; (2) **Inform beneficiaries**, prior to discharge, of (a) their entitlement to Medicare and Medicaid post-hospital benefits, (b) rights of appeal, (c) the identity of the local long term care Ombudsman and (d) nearest location of deficiency reports on local providers under consideration for placement of the patient.

IMPACT OF MEDICARE'S PROSPECTIVE PAYMENT SYSTEM ON THE QUALITY OF CARE RECEIVED BY MEDICARE BENEFICIARIES

Impact on the Post-Hospital Continuum of Care

INTRODUCTION.

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Major findings of this inquiry to date are as follows:

WHAT ARE THE PROBLEMS UNDER PPS?

PROBLEM #1: Under PPS, large numbers of Medicare patients who still need heavy medical care are being discharged to their communities for care.

A Committee staff report and testimony given before the Committee on September 26, 1985 established that many seriously ill Medicare patients are being inappropriately and prematurely discharged under PPS.

PPS Has Increased Demand for Home Health and Nursing Home Care.

Data obtained from reports prepared for HCFA's Administrator clearly demonstrate that there have been substantial increases in discharges of very sick patients in need of heavy nursing care. These data show that for the six quarters (October 1, 1983 to March 31, 1985) beginning at the start of PPS, discharges to skilled nursing homes have steadily increased by almost 40%. Discharges to home health care during that same period have risen by 37% (please see Chart One, next page).

The number of older Americans affected by these trends is substantial. It is estimated that, by the end of the first calendar quarter of 1985, more than 50,000 additional patients were being discharged yearly to skilled nursing facilities and to home health care than had been discharged to these same providers at the beginning of PPS.

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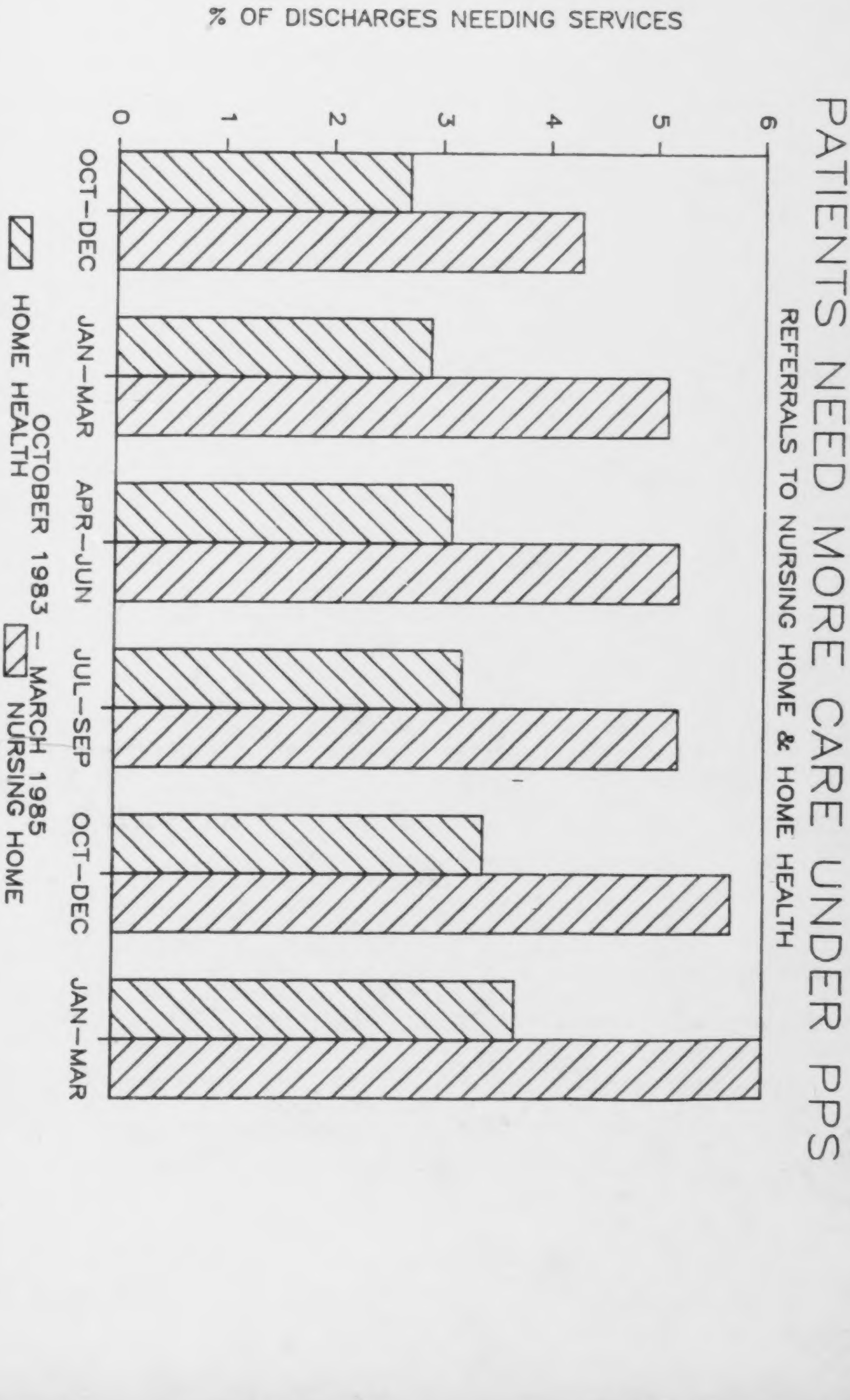
Chart One.



These HCFA data, therefore, indicate a profound shift in delivery of health care since the beginning of PPS: Medicare patients are now expected to receive care in nursing homes and at home for health problems that two years ago would have kept them in a hospital.

Unfortunately, there is inadequate home health and nursing home care available to these patients.

Demands for Nursing Home Care Reflected in Outlays.

In some communities, nursing homes are making fundamental changes in their staffing levels, supplies, and training programs to accomodate the needs of a new population of seriously ill Medicare patients. One indication of this is the significant degree by which Medicare has exceeded its budgetted nursing home outlays.

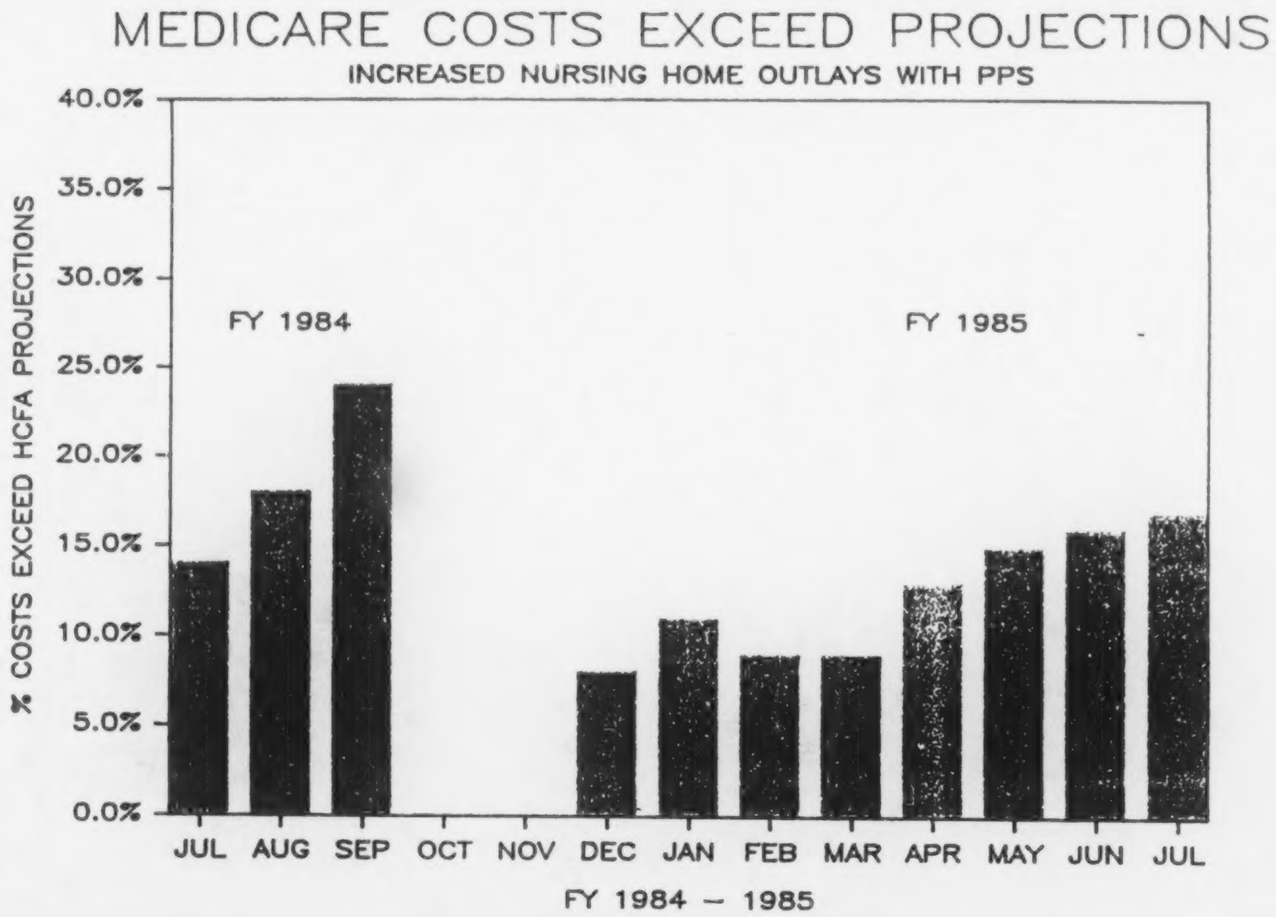
According to the "PPS Monitoring Committee Reports" prepared by senior HCFA staff for the Administrator, expenditures for Medicare nursing home services have been running ahead of projected levels by an average of 14% during the past year. This is a significant change because Medicare's outlays for nursing home services have been relatively stable and predictable for several years. Chart Two (please see next page) shows outlays exceeding budgetted levels by greater amounts each month, as PPS-induced demand for these services increases.

It is likely that these expenditures are rising above projected levels because of the increased number of Medicare patients being discharged from PPS hospitals to skilled nursing homes.

At some nursing homes, this increase in Medicare nursing home admissions has been very evident and has had major repercussions. For example, Chart Three (please see page after next) depicts Medicare admissions rising over 250% at a case study nursing home during the implementation of PPS (this facility will remain unnamed at the request of the administrator.) At this case study facility, the patients now being admitted are much more ill, with many more dying shortly after admission, compared to patients admitted early in the implementation of PPS.

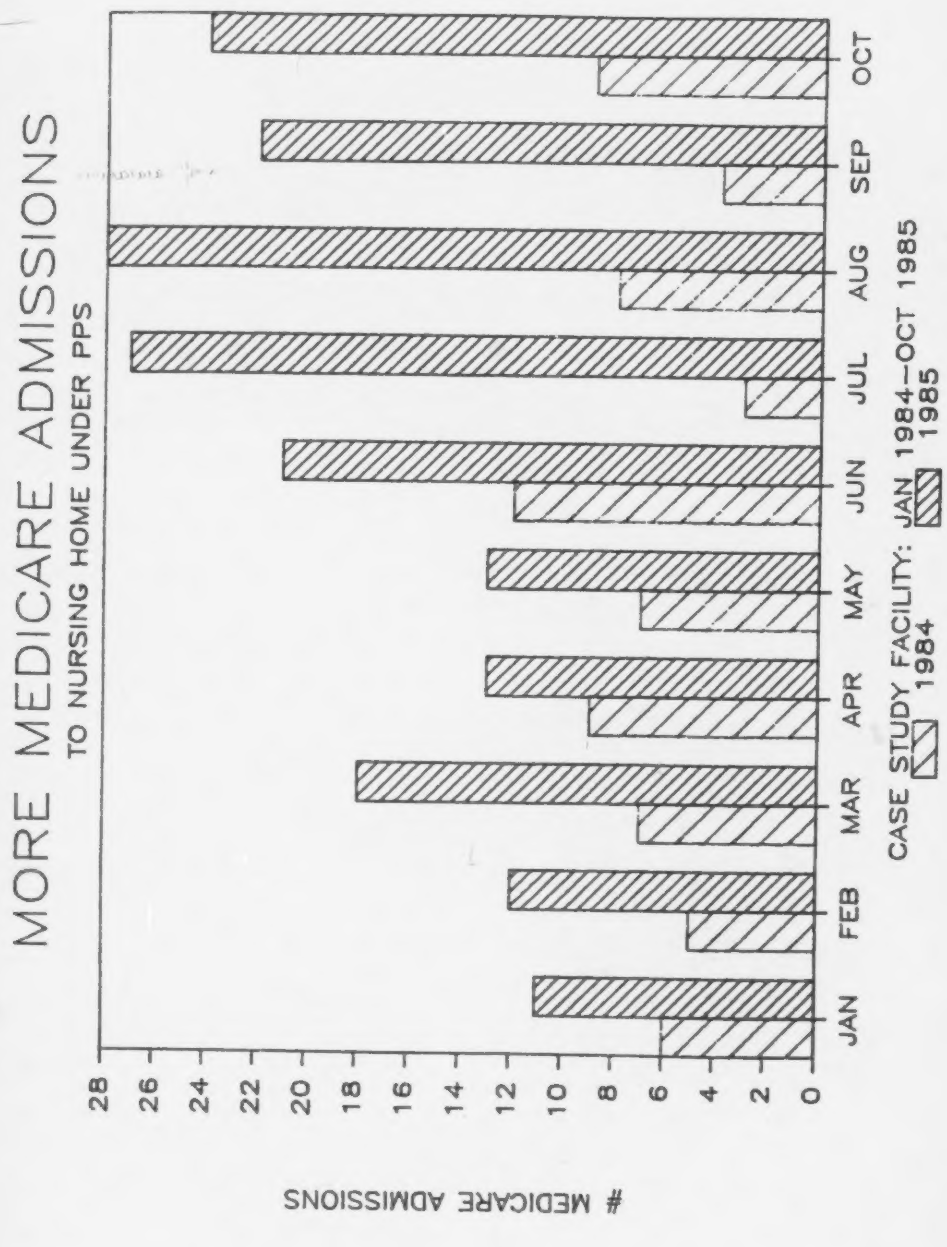
There are three possible ways a nursing home administrator may respond to the 40% increase in Medicare patients being discharged to skilled nursing facilities: (1) do not admit them for care; (2) admit them for care and increase staffing to meet their needs; (3) admit them for care, but do not increase staffing.

Chart Two



MEDICARE COSTS EXCEED PROJECTIONS

INCREASED NURSING HOME OUTLAYS WITH PPS


MORE MEDICARE ADMISSIONS

TO NURSING HOME UNDER PPS

Chart Three

Very few facilities have the resources necessary to "gear up" to meet the heavy care needs of these patients, suggesting that Medicare patients will experience worsening access and quality problems under PPS.

A PPS Trickle-Down Effect.

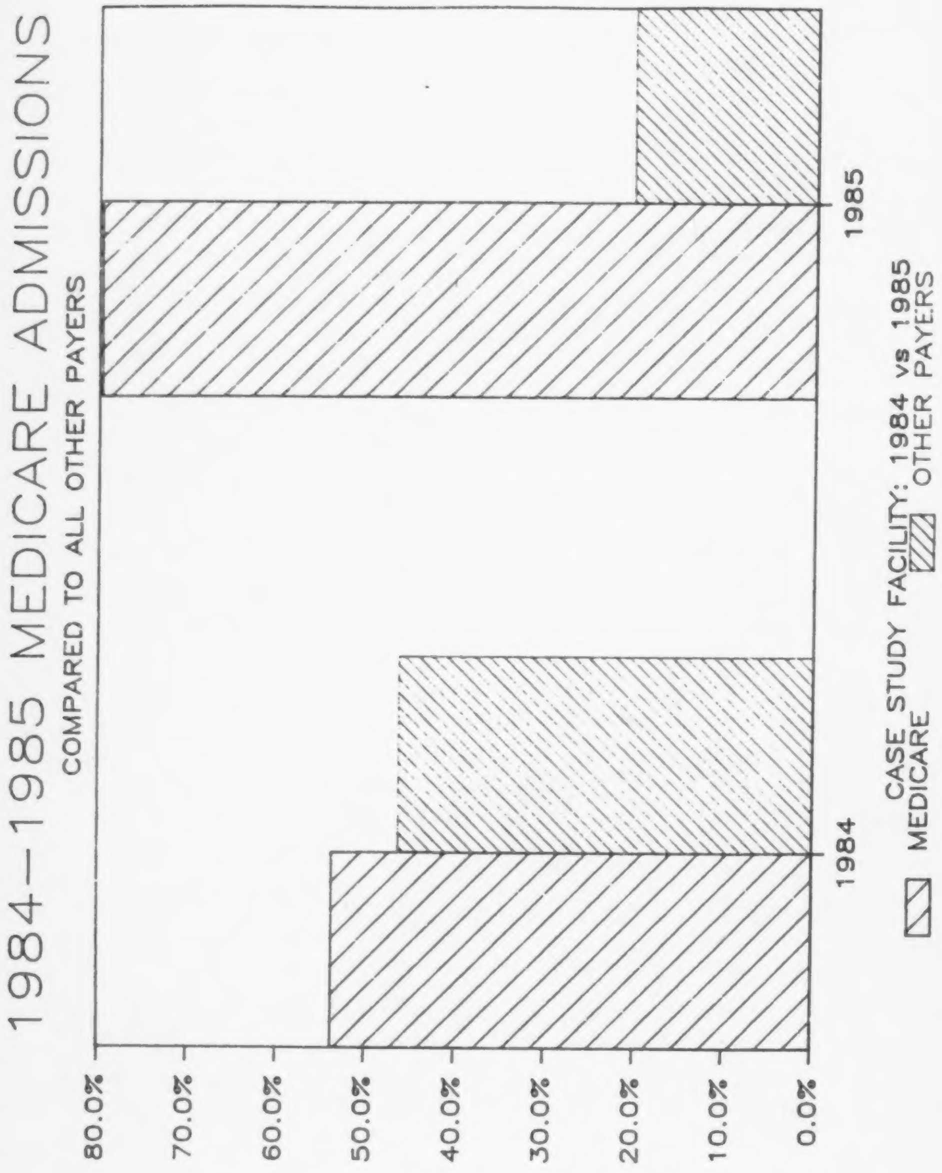
Moreover, because the nursing home industry is in most States operating at or near capacity occupancy levels, an increase in Medicare admissions necessarily means a reduction in available beds for non-Medicare patients. At one nursing home studied by Committee staff, for example, the operator stated that his decision to admit more Medicare patients means that Medicaid eligible, chronic care patients are being admitted less often (please see Chart Four). The only place these patients can now get admitted for care is in Board and Care homes. In his opinion, these facilities are substandard and inadequate to the task of caring for the patients now being admitted.

PROBLEM #2: Home health and nursing home care in the community are often unavailable or substandard.

While there is a severe shortage of nursing home beds nationwide, the problem has historically been greatest for patients needing skilled nursing care. Now that large numbers of much heavier care patients are being discharged from hospitals, some communities, and some entire States, have an inadequate supply of Skilled Nursing Facility (SNF) beds. Medicaid eligible patients in need of skilled care are least likely of all patients to find the nursing home bed they need.

According to testimony before a hearing of the Special Committee on Aging on October 1, 1984, this problem is due in part to State efforts to limit Medicaid expenditures by imposing a moratorium on new nursing home bed construction. A July 1985 survey of State Medicaid programs by the Intergovernmental Health Policy Project (IHPP) confirmed that four States (AL, KY, MN, MS) have extended or initiated new nursing home bed moratoria.

The Committee also received testimony from victims of discrimination and from a former nursing home admissions director, plus evidence from State long term care Ombudsman programs which established that Medicaid-eligible Medicare beneficiaries suffer from widespread illegal discrimination in finding an available nursing home bed. Discriminatory practices are more prevalent where (1) nursing homes are operating at or near capacity, and (2) many people need nursing home care and can bring more money to the nursing home than Medicaid will pay.



1984–1985 MEDICARE ADMISSIONS

COMPARED TO ALL OTHER PAYERS

CASE STUDY FACILITY: 1984 vs 1985

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CHART FOUR

In a State like Pennsylvania, therefore, a large increase in PPS-induced demand will exacerbate the problem of discrimination. Health Department data for all SNFs in that State indicate that the nursing home occupancy rate was 92.5% in calendar year 1983 (pre- PPS). In that year Medicare paid SNFs an average of $13.43 more per patient day than Medicaid paid, providing a substantial financial incentive to displace Medicaid SNF patients with readily available Medicare SNF patients.

A full year after the hearing last fall documented the existence of these problems, however, DHHS has not yet enforced laws barring many common forms of Medicaid discrimination.

Arbitrary Federal Rules Deny Beneficiaries Needed Care.

Federal reimbursement for nursing home care is irrational, disorganized, and bears no practical relationship to the needs of the patient. As a result, patients' access to quality nursing home care is often denied.

Legally, services provided in skilled nursing homes (Medicare calls them "Skilled Nursing Facilities" or "SNFs") are covered under Medicare if they are for "inpatients requiring skilled nursing care and related services ... [or] patients who require medical or nursing care or rehabilitation services for the rehabilitation of injured, disabled, or sick persons" (Section 1816(j) of Social Security Act).

Every nursing home that wishes to receive Medicare or Medicaid reimbursement must be "certified" as a skilled nursing home by a State survey and certification agency under contract with HCFA. State agencies are supposed to abide by the law making Medicare and Medicaid SNF services equivalent.

In addition, Congress created another reimburseable "level of care", to be provided in an "Intermediate Care Facility" ("ICF"), in the mid-1970s. Under this label Congress authorized Medicaid -- but not Medicare -- to pay for the care of patients needing some nursing assistance and monitoring but not sufficiently ill or disabled to require "skilled nursing care".

These distinctions are significant to patients because Medicaid reimbursement rates are lower for ICFs than for SNFs and both Federal and State nursing staff requirements are much more lax for a "custodial" care facility like an ICF than the standards for a quasi-medical facility like a SNF.

The justification for these important differences is that ICFs are supposed to take care of people who are less disabled and require much less care than SNF patients.

In reality, however, a "SNF patient" in one State is called an "ICF patient" by another State certifying agency. Two key differences between nursing homes in different States are:

- the number of Medicare certified skilled nursing homes available in each State;
- the number of qualified licensed nurses on duty to provide skilled care to patients.

These discrepancies can be substantial. For example, the State of California certifies virtually all of its approximately 1200 facilities as "SNF"; while the State of Maine certifies virtually all of its nursing homes at the lower "level of care" called "Intermediate Care Facility".

	Percent of Nursing Homes Certified As	
State	SNF	ICF
Maine	3%	97%
Pennsylvania	69%	30%
California	95%	5%

In addition to the wide discrepancy between States, these ratios can abruptly change in a given State. Since this data was compiled, for example, the State of Pennsylvania Medicaid program decided to redefine the residents of its nursing homes in order to reverse the ratio of SNF to ICF nursing home beds. Now the State has about 30% SNF and 70% ICF.

The number of patients per licensed nurse on duty in Medicare/Medicaid certified skilled nursing facilities in these States is also very different, according to data developed in 1983 by a HCFA contractor (fewer beds per nurse is less workload per nurse):

State	**# Beds per Licensed Nurse in SNFs**
Maine	2.6 beds per nurse
Pennsylvania	8.0 beds per nurse
California	9.1 beds per nurse

These variations have serious implications for beneficiaries' access to services and the quality of the services received. Heavy care patients discharged from PPS hospitals in States with very few SNFs, or in States where the SNFs are only minimally staffed, are likely to receive inadequate nursing home care.

Medicare Often Refuses to Cover Skilled Nursing Care.

Although the law provides for Medicare payments for up to 100 days of care in a skilled nursing home, Medicare seldom pays for more than half this number of days. Between 1981 and 1983 the average was only about 28 days. Moreover, although the law defines as "covered" those services requiring the supervision and observation of skilling nursing personnel, as well as physical therapy, HCFA's Medicare intermediaries deny reimbursement for patients needing physical therapy and skilled supervision so frequently that many providers have stopped billing the program for these services, even though the patient requires them.

When Medicare does not cover skilled nursing home care, patients must pay out of personal funds or must rely on Medicaid to finance their care. Not only is this hard on the patient financially, but it provides another disincentive for the nursing home to submit a bill to Medicare, because the nursing home can get people to pay a higher rate on a private pay basis than Medicare will pay.

Appeals Frequently Overturn Arbitrary Denials.

Beneficiaries may appeal Medicare's denials of Skilled Nursing Facility (SNF) claims. In Connecticut several years ago, State officials began to perceive Medicare's frequent denials of claims clearly covered under Federal law as an effort by the Federal government to shift nursing home costs to Medicaid. As a result, the Medicaid program now provides partial funding to a legal services office, Legal Assistance to Medicare Patients (LAMP), to file appeals on behalf of Medicaid eligible Medicare beneficiaries who are denied Medicare nursing home coverage.

LAMP has filed hundreds of Medicare appeals of nursing home denials over the past several years, winning an astonishing 70% of their clients' appeals. LAMP attorneys discovered that asking fiscal intermediaries -- who make the initial denials -- to reconsider their denials is generally not successful. Intermediaries use the same HCFA guidelines to reconsider cases as they use to initially evaluate a patient's claim for coverage, and generally agree with their earlier decision.

But when appeals are filed with an Administrative Law Judge (ALJ), the rate of overturned denials rises. ALJs base their judgements on the statutory language entitling beneficiaries to the SNF benefit, and on regulations which closely follow Congressional intent. The LAMP experience in filing reconsiderations and appeals suggests

- HCFA's instructions to fiscal intermediaries differ substantially from what Congress intended Medicare to cover under the skilled nursing home care benefit.
- Medicare beneficiaries can fight arbitrary denials by filing appeals with ALJs.

Few Patients Are Prepared to Appeal Medicare Denials.

Patients and their families are unaware of the rules governing Medicare eligibility and appeals until a sudden hospitalization and equally sudden discharge to the disorganized post-acute care continuum confront them with harsh reality: Medicare pays for very little post-hospital care.

As a result, most patients don't know that a Medicare coverage denial can be appealed. If they do appeal, a patient or family must risk thousands of dollars each month on the services under contention, which must be provided in the interim. It can take a year or more to work up to the ALJ level of appeal and actually get reimbursement.

In addition, very few beneficiaries know that in order to appeal a denial a claim must first be submitted by the nursing home. Nursing homes have little incentive to do so, however, so claims are often not submitted to Medicare. Usually nursing home administrators make their own judgement as to whether Medicare will cover a claim, without ever submitting a claim to Medicare, based on their experience with the intermediary and their assessment of the patient's or family's finances. Many then simply tell the patient or family that Medicare would not cover the patient's care.

PPS Forces Discharge to Substandard Nursing Homes.

Even as patients are being forced by PPS to rely upon nursing homes for sophisticated technical and professional nursing care, hundreds of these nursing homes are chronically and repeatedly failing to meet minimal Federal standards of care developed in the 1970s, before heavy care patients began to be admitted to nursing homes for care.

HCFA data, based upon thousands of nursing home inspections across the nation, was analyzed by the DHHS Inspector General at the request of Chairman of the Special Committee on Aging during late 1984 and early 1985. These data indicate that over 970 nursing homes in the United States have been chronically substandard for several years, yet HCFA still permits them to retain their Medicare/Medicaid certification and to continue admitting for care aged beneficiaries of these programs.

HCFA's primary management tool for monitoring nursing homes is a computer data base containing nationwide inspection findings called the "Medicare/Medicaid Automated Certification System" (MMACS). According to the IG, the system is designed

> "...to show the current status of all nursing homes participating in Medicare/Medicaid with regard to inspection and adherence to Federal conditions of program participation."

The IG found that HCFA was not using MMACS effectively to monitor quality of care provided in these institutions, including:

- failure to input into MMACS inspection findings at over 2300 facilities surveyed over a 15 month period following the implementation of PPS;
- failure to identify chronically substandard nursing homes or to prioritize these homes for follow-up action.

Chronically substandard providers have no ability to provide quality nursing home services to Medicare and Medicaid beneficiaries in the era of hospital prospective payment.

Home Health Care Cutbacks Threaten Needed Services Under PPS.

The Medicare program provides for payment under both Parts A and B for an unlimited number of home health services visits as long as the beneficiary is homebound, needs and receives intermittent or part-time skilled nursing and/or rehabilitative services, and is given these services under the plan of care established by a physician.

Services provided under the home health benefit include:

1) part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;

2) physical, occupational, or speech therapy;

3) medical social services under the direction of a physician;

4) part-time or intermittent home health aide services.

The Administration has used rules, unwritten policies, and intermediary manual policies to place limits on the home care benefit that are neither found in statute nor are consistent with public policy set forth by the Congress.

A long-standing controversy has existed over the Adminstration's attempts to redefine "intermittency" in such as way as to deny home health care coverage to many in need of this care. The Medicare program has since 1981 allowed for coverage of part-time daily home health services with the only limitation being that the services are medically reasonable and necessary.

Beginning in early 1984, however, many beneficiaries lost their home health coverage because the local Medicare fiscal intermediary adopted a new interpretation on the home health care benefit, limiting coverage for daily visits to a maximum of six weeks. In Connecticut a fiscal intermediary went further, by attempting to redefine daily care to include care that is given only five days a week.

This important new policy revision did not appear in the Federal Register for public review and comment, leaving the Medicare beneficiaries -- those most directly affected by the change -- entirely out of the decision.

The result of this policy change has been the loss of Medicare financed services to patients. Many cases have been brought before the U.S. District Court and Administrative Law Judges, wherein Medicare beneficiaries have questioned Medicare decisions to deny them coverage of home health care. Most of these cases have been won by the beneficiaries, on the basis that the new policy violates rights to health care services that Medicare beneficiaries are given under law.

Despite this high reversal rate, the policy is still in effect and must be reversed on a case-by-case basis in court.

In another crackdown on home health care benefits during the Fall of 1984, a regional Medicare office in the Northeast established a new unwritten and unpublished policy that disqualified from Medicare coverage many home health patients whose families supplemented the care they received from home health agency employees. For example, if a Medicare beneficiary receives home health aide services 2 hours a day for five days a week and is cared for on the weekends by family members, the beneficiary would be entitled to no Medicare coverage for the home health aide services under this policy.

The rationale behind this new policy is that patients who need part-time home health aide services and also need to have daily personal care services from their family, should be ineligible for Medicare home health coverage since they need more than part-time care.

According to testimony received by the Committee, DHHS has been aware of but has failed to correct this regional policy. The policy is contrary to the Medicare statute, and to public policy regarding home health care as well, which encourages family participation in health care as a mechanism for cutting federal health care expenditures.

These unwritten policies follow three years of administrative attempts to reduce payment for home health agency services, establish beneficiary copayments for home health care services, and eliminate the waiver of liability that provides home health agencies with a small margin for error in making coverage decisions. Yet, with Medicare patients depending upon home health care as never before, all such efforts to limit the scope of this benefit conflict with the policy direction established by PPS.

Administration Drags Its Feet Giving States Flexibility to Establish Community Based Services.

The Home and Community Based Waiver ("Section 2176") program, as signed into law, was intended to provide states with the maximum flexibility needed to develop innovative, budget neutral ways of providing home care as a substitute for costly institutional care.

Until very recently, however, the States lacked fundamental rules and guidance from DHHS to qualify for participation in the Home and Community Based Waiver program. States had to administer the program under ever-changing and ad hoc restrictions and qualifications imposed by DHHS. This Spring, four years after the program began, DHHS finally published these essential program rules.

Unfortunately, these new rules are so cumbersome and unworkable that many States seriously doubt the value of their continued involvement in the program.

HCFA and OMB have curtailed States' ability to replace nursing home care with home and community based care, by redefining the program as a budget cutting tool, and by requiring States to work through a regulatory maze before they can participate in the program.

Despite the tremendous strain placed on nursing home and other community based caregivers by hospital prospective payment, the Administration appears to have undertaken a course of policy action with the Home and Community Based Waiver program that will collide head-on with the incentives of PPS.

PROBLEM #3: Hospital discharge planning -- the only mechanism available to ensure patients are placed in appropriate community settings -- is seriously taxed under PPS and often provides inadequate services to Medicare patients.

Ten years ago, hospital discharge planning at most hospitals was a harried social worker making scores of phone calls to nursing homes to find an empty bed, usually on the same day the hospital said the patient had to go. Since then, at many forward-looking hospitals, discharge planners have been integrated in a team with a nurse, physical therapist, dietician and physician. These professionals consult with one another and with the patient and family to help ensure that quality care does not stop at the hospital exit door.

At most hospitals, however, the quality and professionalism of discharge planning has not improved significantly. At one hospital, for example, the administration sent a laboratory technician to a class and saddled this person with the responsibility of ensuring that patients have someone to take care of them once they leave the hospital.

The absence of Federal requirements in this area is remarkable; in fact, nursing homes have stricter discharge planning requirements than hospitals.

Under PPS, two things have happened to undermine hospital discharge planning: (1) administrators have seen the possibilities of saving money by rapidly discharging patients through a high-volume discharge planning process, and (2) the purpose of discharge planning has been shifted from being focused on the patients' needs to the hospitals' needs.

Recently a survey of over 120 discharge planners was conducted by Dr. John Feather, of the Western New York Geriatric Education Center at SUNY, Buffalo, and Dr. Linda Nichols of the Veterans Administration Medical Center, Memphis. The survey documents the observations of respondents to a series of questions asked before and after the implementation of PPS.

Drs. Feather and Nichols found:

o more hospital administrators recognize the importance of the discharge planner to prompt discharging of patients;

o increased workload for each discharge planner, resulting from more hospital patients -- and sicker patients -- being referred for discharge planning, due in part to Medicare's success in diverting less severe patients for outpatient treatment;

o resources allocated for discharge planning have not risen with workload, resulting in less time being spent on patients. The most dangerous casualty of this trend has been follow up of patients after discharge, which has declined from some 32% of patients receiving follow up attention from the discharge planner to only 15% of patients getting this vital service.

PROBLEM #4: DHHS has failed in its Congressionally mandated responsibility to adequately monitor and report on PPS impact..

Recognizing that reduction of health care utilization through PPS could threaten the quality of care, the Congress, while authorizing PPS in 1983, also directed DHHS to "study and report annually***on the impact" [of the system] on classes of hospitals, beneficiaries, and other payors for inpatient hospital services . ." The first such report, due in December 1984, has yet to be completed and delivered to the Congress.

Further recogizing that PPS might also affect quality of care after hospital discharge, the Congress mandated study of PPS impacts on skilled nursing facilities. The Congress is still waiting for this report which was due last December.

As far as can be determined by Committee staff, the only report produced on a regular basis concerning the status and effects of PPS is produced for internal use by HCFA's PPS Monitoring Committee for the Administrator. The monthly "Report on PPS Monitoring Activities," which has been forwarded to HCFA's Administrator since the summer of 1984, addresses utilization issues only. The report contains information and data on such areas as hospital admissions and discharges, DRG case mix and hospital discharge destination, but contains no reference to quality of care.

DHHS and HCFA responses to this Committee regarding PPS impact on quality of care have at best been confusing and at worst misleading. In mid-1984, when Chairman Heinz had directed Committee staff to conduct a comprehensive inquiry into DHHS claims that PPS was having no adverse impact, HCFA responded in November that it had begun a study to "measure the impact of PPS on home health agencies and skilled nursing facilities. ."

Later, it was learned that HCFA had scrapped the study of PPS impact on skilled nursing facilities. As to the study of PPS impact on home health care agencies, HCFA decided not to publish the findings and, instead, held a "briefing" this past April. The sketchy three-page "briefing paper" stated that the study "shows that there has not been any great change in [hospital] discharges to [home health agencies] or the number of services provided to [home health agency] patients since the start of PPS" (emphasis added). Committee staff, however, learned recently that the study did in fact show an increase in discharges to those home health agencies surveyed. Moreover, during this same period in the spring of 1985, HCFA's Monthly "Report on PPS Monitoring Activities" to the Administrator contained data showing substantial increases to home health agencies as well as to skilled nursing facilites.

Most recently, and following the Committee's investigation and hearing in September substantiating serious problems with in-hospital quality of care, the DHHS responded,". . the Department has taken appropriate action to assure that Medicare beneficiaries receive quality care in a safe environment."

STAFF RECOMMENDATIONS.

RECOMMENDATION #1: Withhold portion of HHS appropriation for FY86 until PPS Impact on Nursing Homes report, with recommendations for reimbursement reform (due 12/31/83), and first Annual PPS Impact Report (due 12/31/84) are delivered to Congress.

RECOMMENDATION #2: DHHS should voluntarily suspend plans to deregulate hospital quality assurance until it reports to Congress on the impact of PPS.

RECOMMENDATION #3: Eliminate current "level of care" distinctions governing nursing home reimbursement under Medicaid, concurrently with mandatory State phase-in of a reimbursement system based upon patients' individual needs and characteristics.

RECOMMENDATION #4: Expand advocacy assistance for older Americans. (1) **Authorize** Long Term Care Ombudsman to have access to hospitalized Medicare patients, interview hospital personnel and, with patient's permission, examine complete hospital record; Mandate State Ombudsman representative on PRO advisory or corporate board; (2) **Fund training** of Ombudsmen in (a) Medicare PPS and (b) all Medicare Part A appeals; (3) **Establish** funding formula for Ombudsman programs based upon workload; (4) **Provide** Ombudsmen with immunity from suits for good faith performance of duties.

RECOMMENDATION #5: Improve Protections for Nursing Home Residents. Congress should enact a minimum set of sanction authorities, which would: (1) **Empower** State enforcement officials to impose receivership on substandard nursing homes, (2) **Provide** Federal Financial Participation (FFP) for care of residents during the period of a receivership; (3) **Strengthen** the Patients' Rights; (4) **Authorize** States to impose civil penalties and suspend reimbursement at noncompliant providers; **(5) Expedite sanction** & provider appeal at chronically substandard nursing homes; (6) **Prohibit discrimination** in admission or treatment of patients based on source of payment; (7) **Empower residents** to enforce provider agreement with private right of action; (8) **Impose moratorium** on HCFA's scheduled January 1986 implementation of new nursing home inspection survey system ("PACS"), for public review and comment.

RECOMMENDATION #6: **Authorize and fund PROs to do expanded quality of care reviews** to (1) nursing homes and home health care agencies to ensure that quality care is planned and delivered after the patient's discharge from a PPS hospital; (2) Increase PRO reviews of readmissions to those occurring within period 30 days.

RECOMMENDATION #7: **Restructure Medicare's eligibility determination and appeals process. (1) Adopt** uniform needs assessment tool for post-hospital benefits, based upon patients' functional abilities, relieve providers of burdensome "UB-82" form; (2) **Institute PRO pre-discharge** eligibility determination for Medicare and Medicaid benefits, with opportunity for patients to initiate appeal prior to discharge; (3) **Eliminate 3-day** prior hospitalization requirement for Medicare SNF benefit; (4) **Mandate appeal** opportunity for beneficiaries when provider fails to submit claim; (5) **Create penalties** for fiscal intermediaries or PROs that improperly deny benefits; (6) **Retain Waiver of Liability** protections for providers.

RECOMMENDATION #8: **Congress should upgrade Federal rules for hospital discharge planning** to include (1) **Pre-discharge consultation** between all professionals giving care to the patient; (2) **Inform beneficiaries**, prior to discharge, of (a) their entitlement to Medicare and Medicaid post-hospital benefits, (b) rights of appeal, (c) the identity of the local long term care Ombudsman and (d) nearest location of deficiency reports on local providers under consideration for placement of the patient.

MEDICARE DRGS: THE GOVERNMENT'S ROLE IN ENSURING QUALITY

STAFF REPORT

Special Committee on Aging,
United States Senate
John Heinz, Chairman

November 12, 1985

Staff Report of the
United states Senate
Special Committee on Aging

MEDICARE DRGS: THE GOVERNMENT'S ROLE IN ENSURING QUALITY

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MEDICARE DRGS: THE GOVERNMENT'S ROLE IN ENSURING QUALITY

A Staff Report of the Senate Special Committee on Aging

November 12, 1985

INTRODUCTION:

The following report has been compiled by the staff of the Senate Special Committee on Aging as a result of an ongoing investigation conducted over a six month period. Staff visited and collected data from five Peer Review Organizations (PROs), and a number of community and university hospitals. In addition, the Committee has heard from witnesses from 14 states.

Throughout this investigation, it has become apparent that the Committee's findings directly and starkly contrast with the claims of the Department of Health and Human Services that quality has not diminished under the new prospective payment system. This report summarizes the findings of the Committee and gives as a point of comparison the position of the Department on these major Prospective Payment System quality issues. The Report also summarizes the recommendations of the staff on what can be done to improve quality of care under the Prospective Payment System.

PROBLEMS, POSITIONS AND FINDINGS:

PROBLEM #1

SERIOUSLY ILL MEDICARE PATIENTS ARE INAPPROPRIATELY AND PREMATURELY DISCHARGED FROM HOSPITALS.

Administration Position:

Carolyne Davis, Administrator of HCFA, 4/19/85 before the Subcommittee on Health of the Senate Finance Committee
"PROs are reviewing the medical records of readmissions within 7 days of discharge and transfer to ensure not only proper utilization, but also to determine that high quality care is not being compromised. Also,-fiscal intermediaries review all transfers to hospital based skilled nursing facilities (SNF) and 30 percent of all transfers to non-hospital based SNFs to assure good quality care and proper utilization. Fewer than 200 cases have been referred to the regional offices so far. This number is insufficient to indicate any patterns [of inappropriate transfers]."

Carolyne Davis 8/9/85 Letter to Senator Heinz
"...While there have been isolated instances of premature discharge and inappropriate transfer, there has been no evidence of systemic abuse."

C. McClain Haddow, Acting Administrator of HCFA, 9/30/85 before the House Budget Task Force on Health
"...There is no data which indicates that the PPS system has adversely impacted in the high quality of care that has been a tradition in our nation's health community."

C. McClain Haddow 10/2/85 on the MacNeil-Lehrer News Hour
"For the first time in history, we are able to identify where [there] are problems of quality of care in the system and we are now not only able to identify them but through the implementation of sanctions against inappropriate providers of care, either the doctors or the hospitals, we are able to correct the problem, to prevent future abuses."

Committee Findings:

GAO Testimony of 11/12/85
HHS lacks any statistically valid basis to confirm or deny effect of DRGs on the quality of health care older Americans need or receive upon discharge from the hospital. Specifically, GAO concludes that HHS does not have the necessary data to evaluate whether PPS has either increased or decreased the quality, access, demand, use or cost of post-hospital care for Medicare beneficiaries. Furthermore, HHS is not planning to do the types of evaluations that are necessary to determine whether PPS is the cause of changes in these five areas.

The Department of Health and Human Services has failed in its Congressionally mandated responsibility to monitor and report on PPS impact.

- Congress mandated that HHS complete by December 1984 a study on PPS impacts, including on quality of care. This report has yet to be completed and sent to Congress. Based on an evaluation of a draft report GAO concludes that there is no analysis of DRG impact on patients' conditions at discharge.
- Congress mandated a study of the impact of PPS on nursing home care. That study, due December 1983, is now 22 months overdue.
- HCFA scrapped a study of PPS impact on skilled nursing facilities and decided not to publish a report on PPS impact on home health care agencies.
- The only regular reports on the effects of PPS -- the "Report on PPS Monitoring Activities" -- are for internal HCFA use only and contain no reference to quality of care.

Investigation by Committee's Staff Physician
Numerous cases of inappropriate discharge from North Carolina hospitals have not been reported by the PRO to HCFA's Regional Office. The fact that almost 50% of the PROs are not reporting casts doubt on the strength of HCFA's assurances on the nature or extent of quality problems.

OTA Report to the Committee 10/24/85
"The amount of funding currently available for an evaluation of PPS within HCFA is inadequate. Budget cuts would exacerbate the problem." The OTA report also notes that while PROs are responsible for protecting against certain extreme effects of DRGs on inpatient care, their responsibility stops at the hospital door.

Richard Kusserow, Inspector General of HHS, Memorandum to Carolyne Davis, HCFA Administrator, 10/23/84.
"The impact of this type of abuse [premature discharges and inappropriate transfers] on quality is so significant that its potential visibility could jeopardize the integrity of the medical review process and the payment system..."

PROBLEM #2

SOME HOSPITALS HAVE DENIED ADMISSION TO PATIENTS WITH MULTIPLE SERIOUS CONDITIONS.

Administration Position:

The Administration has not commented on this issue.

Committee Findings:

Testimony before the Committee 9/26/85
Lydia Thomas described the painful story of her 75-year-old mother who was denied admission to a hospital after a major traffic accident.

Several physicians and hospital administrators described cases where patients deemed "DRG losers" were denied admission or inappropriately discharged from the hospital. (See the Committee Staff Report of 9/26/85 for additional illustrations of this problem.)

OTA Report to the Committee 10/24/85
According to the OTA, PPS provides hospitals with an incentive to deny admission to patients who require heavy resources or have an illness that places them in an "unprofitable DRG".

PROBLEM #3

MANY PATIENTS, ESPECIALLY THE TERMINALLY ILL AND THEIR FAMILIES, ARE BEING GIVEN FALSE, INCOMPLETE -- OR NO -- INFORMATION ON THEIR RIGHTS OF DISCHARGE APPEAL.

Administration Position:

C. McClain Haddow 10/2/85 on MacNeil - Lehrer News Hour
"We absolutely agree that we need patients to be informed of their rights. We require that hospitals post very visible notices upon admission clearly outlining the rights. Every Medicare beneficiary receives a booklet upon eligibility that informs them of their rights and we're working hard to make sure they get the proper kind of..."

Committee Findings:

GAO Report to Committee 2/85
"We were told in site meetings with providers and advocates that beneficiaries are upset and confused about their Medicare benefits and how PPS has affected them. We heard reports that some patients are being told, improperly, that they have to leave the hospital because their Medicare coverage has run out."

Testimony before the Committee 9/26/85 and 10/24/85
Witnesses confirmed that these problems are indeed plaguing patients and their families. For example, several patients were told to leave the hospital within two days or lose their Medicare coverage. They were not told of their right to appeal this discharge decision to the PRO. Other evidence confirmed that patients get the impression that PPS is a change in beneficiaries' coverage when in actuality it is only a change in the method for calculating hospital reimbursement.

Hospitals are required by law (4/17/85 regulations) to "inform Medicare beneficiaries at the time of admission, in writing, that the care for which Medicare payment is sought will be subject to PRO review and indicate the potential outcomes of that review" -- i.e., that the PRO can deny reimbursement. This does not offer the beneficiary any explanation of how to appeal to the PRO as the agent of Medicare, authorized to ensure that Medicare does not pay too much. There is no standard consistent language for hospitals to inform patients about DRGs and PROs and their rights to appeal.

Medicare Handbook
The Administration has not produced helpful explanatory material for beneficiaries about their rights to health care under prospective payment. The Medicare Handbook, Haddow referred to above, was printed in April, 1985. It makes no mention whatsoever of prospective payment or DRGs. It does mention PROs but only to say that they can deny payment for care which is not medically necessary. It does not explain patient appeal rights or the appeal process.

Further, the Administration, citing budget constraints, reduced the number of handbooks printed by more than half - from 6 million to 2.7 million. Local Social Security Offices must make xerox copies to give to beneficiaries.

Apparently recognizing the Handbook's uselessness in terms of explaining prospective payment, the Administration has developed a tiny pamphlet specifically on the issue of PPS. Unfortunately, this pamphlet gives the technical details on how DRGs will be calculated, and how the rates will be phased-in from regional to national rates, but gives beneficiaries absolutely no explanation as to how DRGs affect the limits on days of coverage that Medicare provides or the copayments that are required or how to react to claims that "the DRG is up" or how to appeal to the PRO or even what a PRO is!

Not only is the information on exercising one's right practically nonexistent, but those substantive rights themselves are deficient. Current law contains too many loopholes through which hospitals can escape the responsibility of providing notice and appeal rights to beneficiaries.

PROBLEM #4

SOME HOSPITALS ARE PRESSURING DOCTORS TO TREAT PATIENTS IN WAYS THAT VIOLATE GOOD MEDICAL JUDGEMENT.

Administration Position:

C. McClain Haddow 10/2/85 on MacNeil- Lehrer News Hour
"...[A] doctor can simply say 'I'm not going to do it.' There is no discharge that is allowed under our system without the doctor's signature. We expect that a doctor and a hospital would both be ethical within the standards that are set for them. We actually improve the system because we have standards that they have to meet. If a doctor or a hospital violates those standards, it's a malpractice question. And that, of course, is a very significant deterrent to that kind of behavior...They can go to the PROs, and they can complain and the hospital will be sanctioned."

Committee Findings:

Testimony before the Committee 9/26/85
A physician from a Pennsylvania hospital testified that his hospital had recently decided to warn doctors their privileges could be jeopardized if their patients frequently overstayed the DRG average lengths of stay.

A physician from California testified that one hospital he practices in has begun to pressure physicians toward quicker discharges by publicly ranking and comparing those physicians with longer and more costly patient stays to those with shorter money-saving patient stays.

Physicians' decisions to admit or not to admit patients for hospital care often have been based upon inflexible sets of DRG "cookbook" admission criteria.

A ten-county survey in Tennessee suggests that DRG categories "failed to adequately take into account complications arising during the course of an illness" and result in pressures on doctors to "inappropriately classify the elderly patients with multiple chronic conditions."

See Committee Staff Report of 9/26/85 for further examples.

Code of Federal Regulations:
Mr. Haddow's statement is directly contradicted by HCFA's own regulations which provide that the PRO can override the decision of the attending physician that inpatient care is still medically necessary, and can issue a notice of noncoverage to the beneficiary [see 42 CFR 405.472(b)(iii)(B)].

PROBLEM #5

INFLEXIBLE AND INACCURATE DRG PAYMENTS PROVIDE FINANCIAL INCENTIVES FOR HOSPITALS TO PROVIDE INADEQUATE AND SUBSTANDARD CARE TO SEVERELY ILL MEDICARE BENEFICIARIES.

Administration Position:

Testimony of C. McClain Haddow 9/30/85 before House Budget Task Force on Health
"We are also studying other refinements such as adjusting the rates for severity of illness, and are involved in a comprehensive research effort to determine how to recognize differences in severity among patients with similar diagnoses."

Committee Findings:

Testimony before the Committee 11/12/85
Susan Horn, Ph.D. testified that the DRG system does not account for differences in severity of illness. [Severity of illness refers to the fact that two patients with the same diagnosis may require different levels of care, particularly if one is older or there are other complicating conditions present.] "As a result, equitable reimbursement - system where hospitals are reimbursed inadequately, but not excessively for patient care - cannot be assured under DRGs. This places the heavy care patient in jeopardy of falling victim to a hospital's fear of financial loss and being prematurely discharged, inappropriately transferred, or refused admission. To correct this situation, some reliable measure of severity of illness is needed as part of a system of equitable prospective payment to hospitals."

OTA Report to the Committee 10/24/85
A severity of illness adjustment will give a more accurate reading of the range of patients admitted to a hospital and the efficiency of a hospital in treating them.

Testimony before the Committee 9-26-85
One doctor testified that "doctors are being forced into decisions with regard to the kind of care they give and where they will give it by rigid unreasonable federal guidelines..."

PROBLEM #6

THE HEALTH CARE FINANCING ADMINISTRATION HAS FOCUSED THE PROS ON A VERY NARROW AND INCOMPLETE SET OF QUALITY ISSUES, AND THEREFORE HCFA'S ASSESSMENT OF QUALITY OF CARE IS GROSSLY DEFICIENT.

Administration Position:

Carolyne Davis 7/30/85 before the House Select Committee on Aging
"The PRO program is in place and working. We believe that it is assuring quality of care under PPS."

HHS Secretary Heckler 9/12/85 before Senate Committee on Finance
"There is no evidence of any decrease in the quality of care, according to the information that we have received from the PROs."

C. McClain Haddow 9/30/85 before the House Budget Task Force on Health
"Our monitoring of hospital behavior through peer review organizations indicates that beneficiaries are continuing to receive high quality care."

HCFA publication entitled "Peer Review Organizations: The Who, What, Where, and Why of the 'PRCs'", distributed by the Office of Beneficiary Services.
"What do the PROs do for Medicare? For the time being, the Federal Government has asked the PROs to check three things....(3) Make sure that all of the services a Medicare patient receives meet generally accepted professional standards of quality."

Secretary Heckler 10/2/85 Letter to Senator Heinz
"...the Department has taken appropriate action to assure that Medicare beneficiaries receive quality care in a safe environment."

C. McClain Haddow 10/2/85 on MacNeil-Lehrer News Hour
"But we believe that we are able to control the problem because the PROs identify quality problems and [are] able to act on them."

C. McClain Haddow 11/4/85 on NBC News
"The bottom line is the numbers: how many cases suspected of premature discharges. There are 4,200 out of 2.5 million discharges. That's less than 2/10 of a percent and that's the whole story."

Committee Findings:

Testimony before the Committee 9/26/85
PRO's contractual scope of review is limited to cases where the patient is readmitted to the same hospital within seven days. Thus, cases of readmission after seven days or to another hospital, deaths after premature or inappropriate discharge, denials of admission, inappropriate placement out of the hospital, lack of adequate care in the community etc., are not reviewed by a PRO.

Thomas Dehn, M.D., President of the American Medical Peer Review Association, testified on September 26, 1985 that HCFA primarily wants data from the PROs on utilization of stay--i.e., number of admissions, costs per admission etc.--and is less concerned with quality review. He observed that the PROs "...are somewhat hamstrung by what we consider to be at this juncture a restrictive, underfunded, relatively inflexible, and frankly, too narrowly-focused program of health care review."

In addition, Dr. Dehn said, "...the greatest problem in the PRO program is the fact that it is only a snapshot in the terms of the whole health care continuum....We do not know whether there are premature discharges...because we do not have the opportunity to review the care in that nursing home...".

AMPRA's report, "PROs: The Future Agenda", dated September 1985 and prepared by their Task Force on PRO Implementation, states that "The present quality assurance system required under PRO contracts is limited, restrictive, and lacks the innovation needed at a time when the incentives of PPS raise the potential for compromised care. The imposition of quality objectives presupposes baseline data that can validate the existence of quality problems. Given the advent of prospective payment, no such data is available across a wide spectrum of in-patient care to the elderly. Only now are quality care concerns surfacing."

PROBLEM #7

EXISTING FEDERAL LAW DOES NOT PERMIT PROS TO DENY PAYMENT TO A HOSPITAL OR PHYSICIAN ON THE BASIS OF POOR QUALITY OF CARE.

Administration Position:

The Administration is on record as supporting S. 1623, Medicare Quality Health Care Act of 1985, introduced by Senator Heinz on September 11, 1985.

Committee Findings:

Under current law, when PROs find a utilization problem (such as admission for a procedure that should have been done on an outpatient basis), they can unilaterally deny reimbursement under Medicare. However, when PROs find a quality of care problem, no immediate action can be taken. Instead, they must refer it to the Secretary for an eventual decision on whether to seek repayment from the provider or exclude the provider from participation. Further, the PROs are to report quality of care problems only if there is a pattern of substandard care or one particularly egregious instance.

Testimony before the Committee 9/26/85
Representatives of the American Medical Peer Review Association confirmed that this is a serious loophole in our ability to protect Medicare beneficiaries from poor quality care. (Senator Heinz has introduced S. 1623, the "Medicare Quality of Health Care Act of 1985", which will close this loophole and give the PROs the same authority to pursue quality of care problems that they have to pursue over-utilization problems. This bill has been included in the Senate deficit reduction package.)

PROBLEM #8

LARGE NUMBERS OF MEDICARE PATIENTS WHO ARE DISCHARGED QUICKER, AND THUS SICKER, OFTEN FIND POST HOSPITAL CARE IS UNAVAILABLE OR SUBSTANDARD.

Administration Position:

Carolyne Davis 4/19/85 before the Subcommittee on Health, Senate Finance Committee
". . .[Medicare] reviews all transfers to hospital-based skilled nursing facilities (SNF) and 30 percent of all transfers to non-hospital based SNFs to assure good quality care and proper utilization. Fewer than 200 cases have been referred to the regional offices so far. This number is insufficient to indicate any patterns."

Secretary Heckler 6/19/85 Letter to Senator Heinz
"With respect to your concerns regarding the availability of post-hospital care, we believe that home health agencies and skilled nursing facilities (SNFs) are able to handle the slight increase in volume shown by our PPS statistics."

C. McClain Haddow 10/2/85 on MacNeil - Lehrer News Hour
"Each hospital is required under what we call conditions of participation, is required to have a discharge planning specialist there and that person will assist the person who is about to be discharged to make sure they go to an appropriate setting..."

Committee Findings:

Testimony before the Committee 11/12/85
The General Accounting Office concludes that HHS does not have the necessary data to evaluate whether PPS has either increased or decreased the quality, access, demand, use or cost of post-hospital care for Medicare beneficiaries. Instead, HHS lacks data on quality

of care and can make no legitimate assessment of the quality of care under PPS.

February, 1985, GAO letter report to the Aging Committee
GAO concluded that "evidence of a trend toward increased use of home health services may not be showing up on early reports of the use of Medicare home health services that are based on hospitals' discharge data. . . .A large proportion (in one hospital, 89 percent) of monthly hospital referrals to home health care were not showing up as discharges to home health care on the hospital discharge abstracts processed by the peer-review organizations."

Also in that report, GAO stated that at each site they visited, "the view was expressed . . . that patients are being discharged from hospitals after shorter lengths of stay and in a poorer state of health than prior to PPS."

At two hearings held during September and October of this year by the Committee, witnesses from fourteen States, including beneficiaries, advocates, and health care professionals, testified that premature and inappropriate discharges from hospitals are causing a great deal of suffering, confusion, and loss of life.

Committee Staff Report 10/24/85
Results of a Committee investigation confirm with data from HCFA internal reports a nearly 40% increase in discharges to skilled-nursing and home health care since October 1983. This data also demonstrates the inability of HCFA to estimate the rapid rise in the use of this benefit since the enactment of PPS (Committee Report 10/24/85).

Testimony before the Committee 10/24/85
Providers of post-hospital care confirmed that Medicare admissions to nursing homes have increased dramatically since DRGs began. These witnesses reported that "PPS has resulted in more and sicker patients being released into the community, often to the care of families who are not prepared or able to adequately care for them. . . With the shorter length of stay and reduced staff in many hospitals, patients are often too sick to respond positively to educational efforts and nurses are too shorthanded to spend the extra time" needed to train the patient and the family to provide the care that will be needed at home.

Janet Adair, a home health nurse, told the Committee "In the ten years that I have been in home health care, quality of care was much better before the DRGs were activated. . .We have had to increase our staff to meet the urgent needs of the patients coming home from the hospital."

Despite Mr. Haddow's assertion that all hospitals must have a discharge planning specialist, only hospitals that voluntarily opt to have a Department of Social Work are required to meet Federal rules for discharge planning, and these rules have been criticized as inadequate by the National Association of Social Workers. HCFA plans to do away with even these lax rules.

Existing Hospital discharge planning programs - important mechanisms for assuring that patients are placed in appropriate community settings - are seriously overtaxed under PPS with the result that Medicare patients often receive inadequate post-hospital care.

Testimony before the Committee 9/26/85
Barbara Jones, R.N., a County Health Care Coordinator, described the pressures on home health under DRGs by stating "Home health nurses face a dilemma. Morally, they cannot refuse to provide services ordered and needed, but they sometimes do so knowing that it may not be safe. Patients are not getting adequate care and families are being pushed to the point of exhaustion."

Testimony before the Committee 10/1/84
Home health and nursing home care in the community is often unavailable. Testimony at an earlier hearing of the Committee showed this shortage is aggravated by widespread illegal discrimination against [Medicare and] Medicaid eligible patients. Nursing homes prefer to take patients who will pay higher private rates as well as patients whose conditions are less costly to care for.

Community services are even less available when one looks at the quality of facilities. For example, more than 970 nursing homes have been chronically substandard for years, according to HCFA data, but these facilities still retain their certification to receive Medicare and Medicaid patients.

Administration Cutbacks:
William Dombi, attorney from Legal Assistance for Medicare Patients in Connecticut, testified 10/24/85 that HCFA has "circumvented the law and subverted the intent of Congress....through oral and written policy directives, all designed to curtail home health and skilled nursing facility coverage." Mr. Dombi went further to assert that "there are two Medicare programs, the one that is in the books under 42 USC Section 1395 [and the one based upon the] directives of the Health Care Financing Administration". Other witnesses from the long-term-care provider community confirmed that "patients cannot be admitted for care because of restrictive HCFA guidelines".

Study provided for Committee use by Elayne Kornblatt, PhD
A Virginia study of post-hopital home health care showed that patients need significantly more care since the DRGs were implemented.All patients required more frequent visits and more intense nursing care under prospective payment in the study group.

STAFF RECOMMENDATIONS

PROTECTING QUALITY CARE IN ACUTE-CARE SETTINGS

Recommendation 1: Congress should promptly enact a set of adjustments to the DRG classification system to better reflect differences in severity of illness between patients in the same DRG category.

Recommendation 2: The Secretary should immediately remind Medicare certified hospitals of the illegality, under Section 504 of the Rehabilitation Act of 1973 (as amended), of discriminating against patients on the basis of their disabilities, and initiate enforcement action where appropriate through the HHS Office of Civil Rights.

Recommendation 3: The Secretary should revise the PRO scope of work, now being drafted by HCFA for the second round of PRO contracts, to require comprehensive quality assurance monitoring and enforcement activities.

Recommendation 4: The Congress should pass S. 1623, now incorporated in the Senate budget reconciliation package, which would for the first time authorize PROs to deny reimbursement for substandard care provided to beneficiaries under Medicare, while helping to guarantee the financial viability of the PROs.

Recommendation 5: Congress should authorize and appropriate funding levels for the second round of PRO contracts which will reflect the urgent need for at least as high a volume of quality review as utilization review, and which will reflect, as well, the greater cost per quality review conducted by PROs.

Recommendation 6: Congress should require within each state the creation of a Consumer Advisory Board (CAB) to conduct oversight of the PROs, provide input into the award and evaluation of PRO contracts, and receive input from Medicare beneficiaries and other interested parties. The Board should be coordinated with or otherwise provide for a patient advocacy system to assist the acutely ill elderly and their families. Each Board would be required to make annual reports to the governor and to DHHS. DHHS would be required to utilize CAB input in its decision to award PRO contracts. The CAB should consist of the long term care ombudsman, and protection and advocacy officials in each state, and organizations representing the elderly and disabled.

IMPROVING HOSPITAL DISCHARGE PLANNING

Recommendation 1: Expand existing law, which provides for "Administratively Necessary Days" payments to hospitals for a patient's extended hospital stay when no nursing home bed is available, and to provide for such payments when no appropriate post-hospital care placement -- in terms of the level of skilled care and quality -- can be found at the time of proposed discharge from the hospital.

Recommendation 2: Congress should upgrade Federal rules for hospital discharge planning to include (1) pre-discharge consultation between all professionals giving care to the patient; (2) informing beneficiaries, prior to discharge, of (a) their entitlement to Medicare and Medicaid post-hospital benefits, (b) rights of appeal, (c) the identity of the local long term care ombudsman and (d) the nearest location of deficiency reports on local providers under consideration for placement of the patient.

Recommendation 3: DHHS should voluntarily suspend plans to deregulate hospital quality assurance and discharge planning until it reports to Congress on the effects of PPS.

EXTEND QUALITY PROTECTIONS TO POST-ACUTE CARE SETTINGS

Recommendation 1: PROs' responsibilities for quality assurance should be extended so that they are required to track a pre-specified percentage of patients discharged from the hospital through the continuum of nursing home, home health, and other community-based services.

Recommendation 2: Authorize and fund PROs to do expanded quality of care reviews (1) of nursing homes and home health care agencies to ensure that quality care is planned and delivered after the patient's discharge from a PPS hospital; (2) increase PRO reviews of readmissions to those occurring within a period of 30 days.

Recommendation 3: Congress should authorize the creation of an interagency panel, consisting of representatives of Congress, the Health Care Financing Administration, the Prospective Payment Assessment Commission, the American Medical Peer Review Association, the Department of Health and Human Services' Office of the Inspector General, beneficiaries, and health care practitioner and provider representatives. This panel would make a concerted effort to seek out quality problems, in hospital as well as post-hospital settings, and would develop criteria for a uniform quality of care review system. This panel would report to Congress as soon as practicable on its findings and recommendations.

Recommendation 4: Withhold a portion of HHS appropriations for FY86 until the PPS impact on Nursing Homes report, with recommendations for reimbursement reform (due 12/31/83), and the first Annual PPS Impact Report (due 12/31/84), are delivered to the Congress.

Recommendation 5: Eliminate current "level of care" distinctions governing nursing home reimbursement under Medicaid, concurrently with mandatory state phase-in of a reimbursement system based upon patients' individual needs and characteristics.

Recommendation 6: Expand advocacy assistance for older Americans. (1) Authorize long term care ombudsman to have access to hospitalized Medicare patients, interview hospital personnel and, with patient's permission, examine complete hospital record; mandate a state ombudsman representative on PRO advisory or corporate board; (2) fund training of ombudsman in (a) Medicare PPS and (b) all Medicare Part A appeals; (3) establish funding formula for ombudsman programs based upon workload; (4) provide ombudsman with immunity from suits for good faith performance of duties.

Recommendation 7: Restructure Medicare's eligibility determination and appeals process. (1) Adopt uniform needs assessment tool for post-hospital benefits, based upon patients' functional abilities, and relieve providers of burdensome "UB-82" form; (2) institute PRO pre-discharge eligibility determination for Medicare and Medicaid benefits, with an opportunity for patients to initiate appeal prior to discharge; (3) eliminate 3-day prior hospitalization requirement for Medicare SNF benefit; (4) mandate appeal opportunity for beneficiaries when provider fails to submit claim; (5) create penalties for fiscal intermediaries or PROs that improperly deny benefits; (6) retain waiver of liability protections for providers.

PROTECTING QUALITY CARE IN NURSING HOMES

Recommendation 1: Improve protections for nursing home residents. Congress should enact a minimum set of sanction authorities, which would (1) empower state enforcement officials to impose receivership on substandard nursing homes; (2) provide federal financial participation for care of residents during the period of a receivership; (3) strengthen patients' rights; (4) authorize states to impose civil penalties and suspend reimbursement to noncompliant providers; (5) expedite sanction and provider appeal at chronically substandard nursing homes; (6) prohibit discrimination in admission or treatment of patients based on source of payment; (7) empower residents to enforce provider agreement with private right of action; (8) impose moratorium on HCFA's scheduled Janurary 1986 implementation of new nursing home inspection survey system ("PACS"), for public review and comments.

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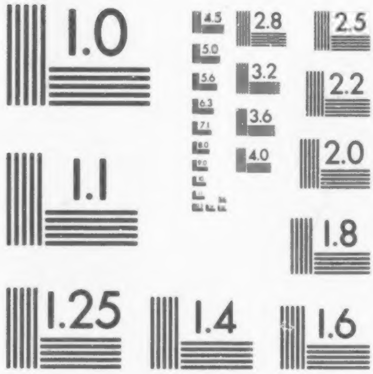

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